WILLOW BEND
VISION CARE

CONSENT FOR RELEASE OF INFORMATION

Patient:_______________________________ Date of birth:_____________________________

I, ________________________________, hereby request and authorize the release of all records pertaining to the patient's (named above) medical history, service renders, or treatment given since __________ to present.

The records from: (please check one)

❑ Willow Bend Vision Care
Fax: 972-202-5630

❑ (Please print name and information of other office)
____
____

Phone:_________________________________
Fax:___________________________________

The records are to be sent to: (please check one)

❑ Willow Bend Vision Care
Fax: 972-202-5630

❑ (Please print name and information of other office)
____
____

Phone:_________________________________
Fax:___________________________________

You are further authorized to communicate with ______________________ either orally or in writing regard the requested information.

This consent is given for the purpose of transfer of records, filling of a current prescription, and continual medical care.

Signature:_______________________________________ Date:_________________
(patient or guardian if under 18)