VISION SOURCE
PROFESSIONAL EYE CARE

I _____, hereby authorize Vision Source
(name of patient)
Professional Eye Care to verbally share confidential information to the following individuals concerning:

- ❑ All matters relating to my health care including the diagnosis, records, examination and prescriptions rendered to me and claims information; or
- ❑ Only my information related to (appointments, prescriptions, billing/insurance, etc) _____; or
- ❑ My information is not to be released to anyone

_____
(name & relationship to patient)

_____
(name & relationship to patient)

_____
(name & relationship to patient)

This authorization may be revoked at any time by notifying Vision Source Professional Eye Care, but the revocation will not affect any actions which have been taken prior to the receipt of the revocation. I understand that this authorization will expire at the end of the calendar year. A new authorization will be required each year.

My signature below authorizes the release of medical information from Vision Source Professional Eye Care to the above named.

_____ _____
(patient signature) (date signed)