InVision Family Eye Care

1211 Hauck Drive
Rolla, MO 65401
Office: 573-364-6300
Fax: 573-341-5058

Consent to Release Medical Information

Patient Name: _____Date of Birth:_____

I, _____ consent _____(Medical Clinic) to release medical records to InVision Family Eye Care.

Doctor: _____
Phone: _____
Fax: _____
Address: _____

All medical records:___ *OR* Dates of Service: _____ to _____

I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon request, for the purpose of healthcare operations (including, but not limited to the providers review functions, claims payments and quality assessment.) I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked. It is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I understand that I have the right to restrict the disclosure of the specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for health care operations.

I have read the above and foregoing consent for the release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and condition of the consent.

Signature:_____ Date: _____