InVision Family Eye Care, LLC
1211 Hauck Drive
Rolla, MO 65401
Phone: 573-364-6300 Fax: 573-341-5058

Consent to Release Medical Information

Patient Name: _____Date of Birth:_____

I, _____, consent InVision Family Eye Care to release:

_____ Contact Lenses

_____ Glasses Order

_____ Medical Records

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: _____