Informed Consent
To Disclose Medical Information
To Visioncare

NAME OF OFFICE_____

ADDRESS_____

PHONE_____FAX_____

I, _____, request the above named facility to Disclose any and all health care records TO VISIONCARE ASSOC.

I understand and acknowledge that my medical records may Contain information regarding Alcohol/Drug abuse, mental health, HIV or Developmental Disabilities. In compliance with Wisconsin Statutes and/or Federal Regulations which require special Permission to release otherwise privileged information, I expressly Consent to the release of any such information contained in the Records designated above.

This informed consent for the disclosure of patient health care Records shall be effective for 1 year from the date of signature.

SIGNATURE_____DOB___/___/___

ADDRESS_____DATE___/___/___

CITY/STATE/ZIP_____

DATE OF SCHEDULED APPT._____

Dr Randall Zieth OD. --- Dr Victor Roeder III OD.

Fax: 920-748-5105