Informed Consent
To Disclose Medical Information
From Visioncare

I, __________________________, request Visioncare Associates to Disclose any and all health care records TO:

NAME OF DR. OFFICE________________________________

ADDRESS____

PHONE____________________FAX_________________________

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