ViewPointe Vision

PERSONAL INFORMATION RELEASE

☐ YES

I, (print) _____ hereby authorize any member of ViewPointe Vision staff to release my personal information, to include health information, to the following people. I also understand that I have the right to remove any person listed below at any time without explanation.

_____ _____
(Name) (Relation to patient)

_____ _____
(Name) (Relation to patient)

_____ _____
(Name) (Relation to patient)

_____ _____
(Name) (Relation to patient)

_____ _____
(Name) (Relation to patient)

☐ NO

I choose not to allow ViewPointe Vision to release my personal or health information to any person other than myself. The only exceptions include the release of information for treatment, payment, or health care operations.

_____ _____
Patient Signature Date