TOMASINO GOERSS
VISION SOURCE

Authorization to release information

I, the undersigned, hereby give my permission and authorization

For: Tomasino Goerss Vision Source
1140 Tom Ginnever Avenue
O'Fallon, MO 63366
Fax # 636-272-1359
Phone # 636-272-1444

To release records requested:

Name: ____

Address: ____

Phone: ____

Fax: ____

Patient Information:

Full Name (please print): ____

Date of Birth: ____

Street Address: ____

City, State, Zip: ____

Reason for Request (circle one): At the request of the individual Other (please explain)
____

Type of records requested: ______________________________________

Patient/Guardian signature: _________________________Date: ______________

You have the right to revoke this at any time by giving us written notice