TOMASINO GOERSS
VISION SOURCE

Authorization to release information

I, the undersigned, hereby give my permission and authorization

For:

Physician's name: _____

Physician's address: _____

Physician's phone and fax: _____

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

Type of records requested: _____

To release records requested: Tomasino Goerss Vision Source
1140 Tom Ginnever Ave.
O'Fallon, MO 63366
Fax # 636-272-1359
Phone # 636-272-1444

Patient Information:

Name (please print): _____

Street Address: _____

City, State, Zip: _____

Patient or Guardian signature: _____Date: _____

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