Schertz Vision Source

17323 IH 35 North, Ste #110 * Schertz, TX 78154 * (210) 651-5800 * (210) 651-9733 Fax
www.visionsource-schertz.com

Medical Information Release Form (HIPAA Release Form)

Patient Name: ______________________________ Patient Date of birth:______________

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse: ____
- ☐ Child(ren): ____
- ☐ Other: ____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Patient/Parent Signature: ________________________________ Date: ______________

Printed name of person completing form: ____