VISION SOURCE®

DR. DAVID WARD, JR. , OPTOMETRIST

PROTECTED HEALTH INFORMATION RELEASE

PATIENTS OVER 18 YEARS OF AGE

Please check all applicable boxes and fill in any blank spaces where information is requested.

☐ Only release information to me personally.

☐ You have my permission to speak with my spouse or significant other about my medical care and test results.

Spouse/Significant Other's Name _____ Phone _____

☐ You have my permission to talk with my children, family members, or others involved with my medical care as listed below.

Name	Relationship	Phone

☐ Other, please describe: _____

Emergency Contact Information

Name (first and last): _____ Phone# _____

City/State/Zip: _____ Relationship to pt: _____

Patient Contact Information

Cell # _____ Home # _____ Work# _____

Email Address _____

May we contact you at the above email address? Yes No

_____ _____ _____

Print Your Name Here *Signature* *Date*

Please review the above information. Make appropriate changes, then Patient or Guardian please initial and date below.

	Date	Initial		Date	Initial		Date	Initial
Reviewed			Reviewed			Reviewed		
Reviewed			Reviewed			Reviewed		