



V I S U A L E Y E S

ESTd 2016

G. Chad Green, O.D.
1490 Northbank Parkway, Suite 120
Tuscaloosa, AL 35406

PERMISSION TO RELEASE INFORMATION

If you anticipate the need for anyone else to have access to protected health information about you, please complete the following information.

I (we), the undersigned patient and/or responsible party hereby authorize VisualEyes, its doctors, agents, employees or representatives to discuss or release any or all patient information about me including, but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc. to the person or persons indicated below:

Spouse	Name:
Parents	Name(s):
Children	Name(s):
Other	Name(s):

This authorization will remain in effect until revoked by written request to this office.

Patient Signature: _____ Date: _____