VISION SOURCE®

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

James C. Frangos, OD
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Dover, NH 03820
(603) 742-7371

_____
PRINT YOUR NAME

Please check all that apply:

The staff has my permission to:
____ leave a message at home
____ leave a message on my cell
____ contact me by email
____ other_____

The staff has my permission to discuss my condition and/or treatment:
____ Spouse _____
____ Children _____
____ Significant other _____

The staff has my permission to fax the following when verbally or otherwise requested:
____ Invoice/itemized receipts
____ Prescriptions

_____ _____
SIGNATURE DATE