VISION SOURCE®

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

COCHECO EYE CARE

C. Andrew Frangos, OD

15 Portland Avenue
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 _____
____ Parent _____

The staff has my permission to email/fax the following when verbally or otherwise requested:

____ Invoice/itemized receipts
____ Prescriptions

_____ _____
SIGNATURE DATE