4033 Eastern Sky Dr.
Traverse Ciy, MI 49684
231.932.9000
231.932.9156 f

Consent to Release Information

Patient Name: _____ DOB: _____ Acct #: _____

Address: _____ City:_____ State: _____ Zip; _____

Phone: _____ Home/Cell Alt. Phone: _____ Home/Cell

I hereby authorize Northern Vision Eye Care to release to or discuss my medical information with:

Name: _____ Relationship to patient: _____

Address: _____ City:_____ State: _____ Zip; _____

Phone: _____ Home/Cell Alt. Phone: _____ Home/Cell

Name: _____ Relationship to patient: _____

Address: _____ City:_____ State: _____ Zip; _____

Phone: _____ Home/Cell Alt. Phone: _____ Home/Cell

Which may include:

- ☐ Past and current medical records
- ☐ Billing/ Insurance records
- ☐ Appointment information

Patient Signature: _____ Date: _____

Guardian Signature:_____ Date: _____

Witness: _____ Date: _____