FALL RIVER
—VISION—

Permission to Share Medical Information

You have a right to determine how your medical information is shared.

I authorize Fall River Vision to inform the below person(s) of all of my personal information including but not limited to: medical diagnoses, medical history, medications, insurance and contact information, balances etc.

Person #1 Name: _____ Relationship:_____ Phone Number_____

Person #2 Name: _____ Relationship:_____ Phone Number_____

Person #3 Name: _____ Relationship:_____ Phone Number_____

I authorize Fall River Vision to leave messages regarding my personal information including but not limited to: medical diagnoses, medical history, medications, insurance and contact information, balances etc. at the following phone numbers/email addresses which belong to me:

Phone Number: _____ Email: _____

Patient Printed Name_____

Patient Signature_____ Date_____

* If patient is under 18, signature of guardian.