MAY VISION CENTER
330 North Century Ave, Waunakee, WI 53597
Phone 608-849-Eyes(3937)
Fax 608-849-5177
www.visionsource-mayvisioncenter.com

Authorization to release patient information

I _____ give _____
(Patient Name) (Name of Parent, Spouse, etc.)
permission to have access to my medical records and account information at May Vision center.

I understand that I may revoke my authorization at any time. This Records Release form will expire 12 months from the date signed.

SIGNATURE: _____ **DATE:** _____
(Patient)

VISION SOURCE™