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RELEASE OF INFORMATION

I, _____, give my permission for Premier Eyecare, Angela Tsai, O.D. and Associates, P.C. to release/dispense my (please circle) medical records, insurance information, billing statements, prescriptions, contact lens, eyeglasses, and/or medications to the following person(s) listed below. I understand that it is my responsibility to follow-up with the person(s) listed below to receive the reports or item. I understand Premier Eyecare, Angela Tsai, O.D. and Associates, P.C. is not responsible for loss, stolen, or misuse of information or items released to the person(s) listed below.

I, _____, understand if my records are subpoenaed by law, that Premier Eyecare, Angela Tsai, O.D. and Associates, P.C. must furnish medical reports and billing.

You may also request a restriction on disclosure of protected health information to a health plan for purpose of payment or health care operations if you paid for the services, at the time of the services, out of your own pocket in full. This does not apply to services that are covered by insurance.

Release to: (This includes, but is not limited to, spouses, parents, grandparents, schools, or other health care professionals. Please list the relationship to the patient.)

(1) _____

(2) _____

(3) _____

(4) _____

(5) _____

Signature _____ Date ____/____/____