Weber Eye Care

Ruth A. Weber, O.D.

Authorization for Release of Vision Health Records:

Patient Name_____DOB_____

Address_____

City_____ State_____ Zip_____

Telephone_____

Reason For Release: ◯ Continued Care with Ruth A Weber O.D.

◯ Other _____

Please Fax to: 920-748-1492 or Mail to:
Weber Eye Care
1081B West Fond Du Lac Street
Ripon, WI 54971
920-748-1497

Requesting Information From

Facility Name_____

Address_____

City_____ State_____ Zip_____

I, the undersigned, give the above facility, permission to release my medical records.

Signed_____ Date_____

This authorization for disclosure of information is effective until: _____unless revoked by the patient in writing before that date.