Mud Springs Vision Clinic Inc.
404 9th St. Wheatland WY 82201
307-322-9747

Patient Name (please print) _____

I authorize Mud Springs Vision Clinic Inc. to release my personal health information to the following individuals:

_____

_____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____/_____
Patient Signature / Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ / _____
Representative Signature / Relationship to Patient

_____
Other individuals authorized to make legal decisions for the minor