2215 Vine Street, STE E1* Hudson, WI 54016
Phone: (715) 381-1234 Fax: (715) 381-5357
EMAIL: info@christensonvisiontherapy.com

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION AND TRANSPORTATION TO AND FROM VISION THERAPY APPOINTMENTS

PATIENT'S NAME:____ DATE OF BIRTH:________________

STREET ADDRESS ____

CITY, STATE, ZIP: ____ PHONE: ______________________

[ ] I authorize Christenson Vision Therapy Center to discuss my child's vision therapy treatment to:
[ ] I authorize Christenson Vision Therapy Center to release my child for transportation to and from vision therapy visits to:

____
NAME

____
ADDRESS/ CITY, STATE, ZIP CODE

____
PHONE NUMBER

____
RELATIONSHIP TO PATIENT

X____ Date _________________
Signature of Patient or Patient's Authorized Representative Relationship [ ] Parent [ ] Legal Guardian or Executor

X____ Date _________________