



RETINA CENTER
OF VERMONT

I, _____, hereby authorize Retina Center of Vermont to release my personal healthcare information to the following:

Name: _____

Address: _____

Phone: _____

Fax: _____

Relationship: _____

Name: _____

Address: _____

Phone: _____

Fax: _____

Relationship: _____

Patient Signature: _____

Date Signed: _____

Patient DOB: _____

RCV Account Number: _____