Quality Vision Care
Jenét Melton, OD

1040 Partridge Place Suite 10
Helena, MT 59602
406-449-EYES (3937)
Fax # 406-449-6932

Date: ________________________ Phone: ____________________________

ATTN: ______________________ Business: ___________________________

Fax: _________________________ Address: ___________________________

Medical Record Release

I, ____ authorize the release of my child's medical records ***to Dr. Jenét Melton, OD*** at Quality Vision Care.

Childs name _______________________________ ____/____/______
Child's Date of Birth

____
Parent Signature

Thank you.

Please fax the records to Quality Vision Care @ 449-6932.

Confidentiality/HIPPA Notice: The personal health information contained herein is privileged and highly confidential. It is intended for the exclusive use of the person to whom it is addressed and is only to be used to aid the recipient in providing healthcare services to this patient. Any other use or disclosure is a violation of Federal Law (HIPPA) and will be reported.

If this communication has been received in error, please notify Quality Vision Care by telephone (406-449-6932) immediately.