GENERAL CONSENT FOR TREATMENT

PATIENT:_____ Date:_____

I voluntarily consent to medical services and minor procedures under the general specific instructions of Michael D. Tschoepe, M.D. or covering physicians as is necessary.

I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatments or examination by Michael D. Tschoepe, M.D.

_____
Signature of patient/Parent/Legal Guardian

RELEASE OF INFORMATION

RealEyes Vision Center, Michael D. Tschoepe, M.D. and staff/representatives have my permission to provide PROTECTED HEALTH INFORMATION regarding my care/ release prescription information/ release written prescriptions or prescription samples to the following:

Attending Physician:_____ _____
Name of Physician Name of Physician

Family Members: _____ _____
Name Relationship to patient Name Relationship to patient

_____ _____
Name Relationship to patient Name Relationship to patient

_____ _____
Name Relationship to patient Name Relationship to patient

Care Giver:_____
Name Address Phone #

Pharmacy:_____
Name Phone #

School:_____
Name of school

RealEyes Vision Center/ Michael D. Tschoepe, M.D./ Staff/ Representatives have my permission to leave messages on my answering machine for reminders for appointment times and dates and normal test results. ☐Yes ☐No

OR, a message with the above information may be given to the following person (s):

_____ _____
Name Name

_____ _____
Name Name

_____ _____
Signature of Patient/ Parent/ Legal Guardian Date