HELLERSTEIN & BRENNER
VISION CENTER, P.C.

LYNN F. HELLERSTEIN, O.D., F.C.O.V.D., F.A.A.O. • TRICIA BRENNER, O.D. • SARA K. GRELL, O.D. • AMY E. ELSILA, O.D. • ALEXANDRIA R. WISS, O.D.

NAME: ________________________________

HEAD TRAUMA/STROKE RELEASE FORM AND NARRATIVE REPORT RECIPIENT LIST.
Please include below all those with whom you would like the doctor to be able to communicate.
Check those who you authorize this office to release information to.
(All information needs to be filled out completely) NARRATIVE REPORT:

Lawyer Name: ____ _____

Address:____

Phone:_________________________ Work:________________

Insurance Contact Name:______________________________ _____

Phone:________________Date of Accident:________________

Claim #:_________________ Policy #:____________________

S.S.#:_______________ Company Name:___________________

Address:____

Dr., Osteopath or Chiropractor:_________________________ _____

____

Address:____

Other:____ _____

Address:____

I hereby authorize the release and communication of information both written and verbal between this office and the parties above.
Signature: _________________________________ **Date:**____________