HELLERSTEIN & BRENNER
VISION CENTER, P.C.

TRICIA BRENNER, O.D. • SHELBY RILEY, O.D. • SARA GRELL, O.D. • KYARA FARINELLA, O.D. • AMY OVERLAND, 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:**_____