PULLMAN
VISION SOURCE®
JAMES P. DEVLEMING, O.D. JENNA DEWALD, O.D.

_____ authorizes James P. DeVleming, O.D. to release his
Print name(s)
or her records to the following:

_____
Provider name/location

_____ _____
Telephone Fax

All records ☐
Spectacle records ☐
Contact lens records ☐

Signature:* _____ Date: _____

If signed by a patient representative, state name and relationship to patient: _____

In accordance with the **HIPAA PRIVACY ACT this form must be filled out by the patient requesting the release of his or records OR his or her legal guardian or representative.*