EYE-DEAL VISION
DR. THOMAS VIELMA
THERAPEUTIC OPTOMETRIST
OPTOMETRIC GLAUCOMA SPECIALIST
2412 Irving Mall
Irving, TX 75062
(972)258-2222

HIPPA PRIVACY ACT SUPPLEMENTAL FORM

Date: _______________

Patient's Name: ___________________________

In the event that you may want a family member or friend to discuss your vision treatment with our office, we must have in writing permission/consent from you to do so. **Please list any person you give Dr. Thomas Vielma permission/consent to discuss your vision treatment.** If you do not wish to give consent to any person, check the appropriate box and sign/date the bottom portion of this form.

Name: ___________________________________
Name: ___________________________________
Name: ___________________________________

If the patient is a minor, we will discuss vision treatment with either parent/guardian.

☐ I hereby give permission/consent to Dr. Thomas Vielma to discuss any and all vision treatments with the above named individuals.

☐ I do not wish Dr. Thomas Vielma to discuss any of my vision treatments with anyone other than me.

____ Date: ______________
Patient's Signature (Parent/Guardian signature if patient is a minor)