Vision Therapy Centers, SC
1401 McMahon Dr., Suite 100
Neenah, WI 54956

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

Name of Patient/Previous Names _____ Birth Date/Medical Record Number _____

Street Address _____ City, State, Zip Code _____

AUTHORIZES:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip Code _____

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip Code _____

INFORMATION TO BE RELEASED:

	~~Date of Service~~
☐ Complete Records	_____
☐ Visual Fields	_____
☐ Contact Lens info.	_____
Spectacle info.	

	Date of Service
☐ Surgical Records	_____
☐ Academic Records	
Other _____	

THIS DISCLOSURE IS BEING MADE FOR THE FOLLOWING PURPOSE(S):

☐ Vision Therapy
☐ Payment Process/Insurance/Billing Difficulties
☐ At the Request of an Individual
☐ Other (comments) _____

REDISCLOSURE NOTICE: I understand that if the person(s) and /or organization listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting A B See Vision Therapy Centers. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** - I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Revoke This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact A B See Vision Therapy Centers. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. A B See Vision Therapy Centers reserve the right to charge for the copying of medical records as permitted by law.

Expiration Date: This authorization is good until the following date(s)_____or for one year from the date signed. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEGAL REP: _____ **DATE:** _____

(If signed by other than patient, state relationship and authority to do so.)

☐ Parent ☐ Guardian ☐ POA for Healthcare ☐ Spouse/Adult Family Member of Deceased Patient

Patient is: Minor Incompetent Disabled Deceased