Authorization for Release of Medical Information

Patient Information:

Name:	
Address:	
Birthdate:	Phone Number:

Medical Records to be disclosed: (Please check one box)
□ Medical Records □ Billing Records □ All Records
□ Other_____

I hereby authorize the below providers to release my medical records to **New Horizons Vision Therapy Center & Dr. Valerie Frazer.**

Release From:
Name (Health Facility, Physician…):_____
Address:_____

Name (Health Facility, Physician…):_____
Address:_____

Name (Health Facility, Physician…):_____
Address:_____

Expiration date (if any) relating to the individual or purpose for the release: _____
It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Date: _____ Patient signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient _____ Print Name _____

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