CENTER FOR VISION & LEARNING

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ DOB: _____

Directive: ***(Check one)*** **□ Requesting records from:** **□ Sending records to:**

Doctor/Clinic: _____

Address: _____

Phone: _____ Fax: _____

Directive: ***(Check one)*** **□ Sending records to:** **□ Requesting records from:**

Doctor/Clinic: Center for Vision & Learning

Address: 728 Tamiami Trail North, Naples, FL 34102

Phone: 239-682-0945 Fax: 1-888-977-1278

I authorize the professional office of my doctor named above to **release health information or receive health information** identifying me or my child (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

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 form.

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 note telling us that your authorization is revoked. Send this note to either Dr. Matthew Walsh or the Office Manager of Center for Vision & Learning.

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.

Patient/Parent Signature _____ Date _____