



Vision Therapy Centers, SC
1466 Kenwood Dr.
Menasha, WI 54952

Dr. Linda Dejmek O.D.,FCOVD
Neuro-Developmental
Optometrist

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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:

RELEASE OF PROTECTED HEALTH INFORMATION TO:

Name of Health Care Provider/Plan/Other

Name of Health Care Provider/Plan/Other

Street Address

Street Address

City, State, Zip Code

City, State, Zip Code

INFORMATION TO BE RELEASED:

	<u><i>Date of Service</i></u>
<input type="checkbox"/> Complete Records	_____
<input type="checkbox"/> Visual Fields	_____
<input type="checkbox"/> Contact Lens info.	_____
<input type="checkbox"/> Spectacle info.	_____
<input type="checkbox"/>	_____

	<u><i>Date of Service</i></u>
<input type="checkbox"/> Surgical Records	_____
<input type="checkbox"/> Academic Records	_____
<input type="checkbox"/> Other _____	_____
<input type="checkbox"/>	_____

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