Vision Associates

AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION

2865 N. Reynolds Rd #170
Toledo, OH 43615

Phone : 419-578-2020 Fax : 419-539-6323 www.visionassociates.net

Patient Full Name (First, Middle, Last): _____

Date of Birth: _____ Patient Address: _____ Phone: _____

Dates of services (from - to): _____

I hereby authorize Vision Associates to (select one): ☐ Obtain from ☐ Release to ☐ Share/discuss with

Name/Facility: _____ Attention: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Check the following information to be released for the dates of service indicated above. The disclosure may include paper, oral and electronic interchange.

___ Entire Medical Record (*Does not include HIV/AIDS Testing, Drug and Alcohol Information, or Psychotherapy Notes. To authorize the disclosure of this information, you must also check below*)

___ HIV/AIDS Testing ___ Drug and Alcohol Treatment Information ___ Billing Statement
___ Psychiatric Diagnostic Evaluation ___ Progress notes ___ Current Treatment Plan
___ Medications ___ Discharge Summary
___ Records Pertaining to care on the following dates ONLY: _____
___ Other (must specify): _____

Purpose(s) of Disclosure: ___ Coordination & Continuity of Treatment ___ Personal ___ Legal ___ Insurance
___ Transfer from Practice ___ Other (explain): _____

This authorization for the release/obtaining of information will automatically expire ninety (90) days after the date of the authorization unless I agree to a shorter or longer authorization period as noted below. Maximum period is 365 days.

Expiration date: _____ Condition, date or event of earlier/later expiration: _____

- I understand that if the recipient of the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such recipient and will likely no longer be protected by federal privacy regulations. I understand that Vision Associates cannot control the recipient's use of the disclosed information.
- I understand that authorizing the use or disclosure of the above information is voluntary. I understand that Vision Associates will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this authorization.
- I understand that I can revoke this authorization at any time, except to the extent that action has been taken by Vision Associates in reliance on this authorization, by sending a written revocation to Vision Associates, 2865 N. Reynolds Road, Toledo, Ohio 43615, Attn: Medical Records Department. Upon revocation of this authorization, further release of information shall immediately cease.
- For more information about your privacy rights, please refer to Vision Associates' HIPAA Notice of Privacy Practices

_____ ___ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Relationship of Authorized Representative (if applicable) Name of staff member facilitating this request