Boulder Valley Vision Therapy, P.C.
1790 30th Street, Suite #311
Boulder, CO 80301

Jennifer S. Simonson, OD, FCOVD
Phone = 303-443-2257
Fax = 303-443-4599

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient address _____

Patient phone number _____

I authorize the professional office named below, to release health information identifying me [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:

1. **Description of the information to be released:**

☐ Pertinent Medical Records ☐ Most recent prescription(s) ☐ Other:_____

2. ☐ **Release information from Boulder Valley Vision Therapy, P.C. to the office named below:**

or ☐ **Release information from the office named below to Boulder Valley Vision Therapy, P.C.**

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

3. **The purpose(s) for the release:**

☐ At the request of the individual ☐ Other:_____

4. **Today's Date:** _____

Expiration of this release from today's date: ☐ 6 Months ☐ 1 Year ☐ Other:_____

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.

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 signature _____ Dated _____

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 _____

Source of Authority _____