Authorization to Release Health Care Records

(3rd party authorization)

Patient Name ________________________________ Date of Birth _______________
Address ____

I request and authorize:

InVision Eye Health

Dr. Brenden White, O.D.
Dr. Brittany Capstick, O.D.
Dr. Steven Sargent, O.D.
Dr. Christopher Snow, O.D.

10835 So. 700 E. Sandy, UT 84070

Phone: (801) 495-2020 Fax: (801) 984-5665

To release my health care information to:

Name: ____________________________ Phone Number: ______________________

Address: ____

Relationship to Patient: ____

From the date of this Authorization until: _____________________________________

*Unless otherwise noted above this authorization will remain in effect 365 days from the date signed

This request and authorization applies to

_____ All health care information _____ Other: ________________________

_____ All eye care records _____ Verbal communication with office

_____ Last exam only (order materials and request vision Rx)

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, and/or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Patient or Guardian Signature __________________________________ Date: _________

Print Name and Relationship if signed by person other than patient:

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