Authorization to Release Health Care Records

Patient Name _____ Date of Birth _____
Address _____

I request and authorize:

Doctor or Facility: _____

Phone Number: _____ Fax Number: _____

To release my health care information to:

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

This request and authorization applies to

_____ All health care information _____ Other: _____

_____ All eye care records _____

_____ Last exam only _____

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:

_____