Center for Better Learning

Better Vision. Brighter Future.

RECORDS RELEASE FORM

Patient Name: _____

DOB: _____ Phone: _____

By signing this form, I authorize Center for Better Learning to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to:

- ☐ Optometrist: _____Phone: _____
- ☐ Pediatrician: _____Phone: _____
- ☐ Occupational Therapist:_____Phone: _____
- ☐ Physical Therapist: _____Phone: _____
- ☐ Psychologist/Psychiatrist: _____ Phone: _____
- ☐ Other: _____ Phone: _____

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign, please complete the following:

Signature of Authorized Representative: _____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient: ☐ Parent ☐ Legal Guardian ☐ Court Order

- ☐ I understand that my records may contain information regarding a diagnosis or treatment. I authorize the use or disclosure of the above specified information to be retrieved for medical purposes only.
- ☐ I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reached the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.