



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____

Patient DOB _____

I hereby grant permission for InVision, LLC to release all records pertaining to the patient's relevant health history, diagnosis, and treatment documentation to the following agencies:

1. Agency Name _____

Address _____

Telephone _____ Fax _____

2. Agency Name _____

Address _____

Telephone _____ Fax _____

Signature _____ Date _____

Patient or Guardian/Agent