AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)

Patient Information

Patient Name: _____ Date of Birth: _____

Records Requested From (check all that apply)

☐ Primary Care Provider
☐ Specialist (type): _____
☐ Optometrist / Ophthalmologist
☐ Therapy / Rehab Facility
☐ Other: _____

Facility / Provider Name:

Address:

Phone: _____ Fax: _____

Description of Information to Be Released (check at least one)

☐ All medical records on file
☐ Most recent records only

Signature

Patient / Legal Guardian Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: _____

Patient Rights & Acknowledgements

I understand that I may revoke this authorization in writing at any time. I understand that information disclosed may be subject to re-disclosure. I understand that treatment is not conditioned on signing this authorization.

2500 Louisiana Blvd NE, Suite 400 • Albuquerque, NM 87110
• phone 505-341-2020 • fax 505-286-6152 **www.invisionvt.com**