Arizona Vision Therapy Center

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RELEASE OF INFORMATION

Patient Name: _____ **Date of Birth:** _____

It is often beneficial to discuss evaluaiton and treatment information with everyone that is involved with a patient's health care and wellness. By signing this agreement, I agree to release examination and treatment records to the following names listed below. This authorization shall be considered valid throughout the duration of treatment.

Please list below all providers you would like to authorize to receive evaluation and treatment information.

Optometrist	Phone
Therapist	Phone
Teacher/School	Phone
Pediatrician	Phone
Other	Phone
Other	Phone

I wish to withhold my evaluation and treatment information from the following individuals:

Name	Relationship to patient
Name	Relationship to patient

_____ _____

Signature (Patient, Legal Guardian, Personal Representative) **Date**

_____

Print Name and Relationship if not patient