Behavioral Optometry • ***Vision Therapy and Rehabilitation***
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Permission to Release Patient Records:

Patient: _____ **Date:** _____

DOB: _____

I hereby authorize use or disclosure of protected health information about me/ as described below:

(*circle direction of information exchange)*

_____ → From/To: → ☐ Samantha Slotnick, OD

_____ ☐ ← To/From: ← 495 Central Park Ave, Ste 301

_____ ☐ ←→ **Both** To/From: ←→ ☐ Scarsdale, NY 10583

_____ Fax: **(914) 885-1463**

The specific information that should be disclosed is (please give dates of service if possible):

_____

_____

_____

UNLESS YOU SIGN HERE,
NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
***YES**, DISCLOSE THIS INFORMATION* *_____
***NO, DO NOT** DISCLOSE THIS INFORMATION* * _____

1. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
2. I may revoke this authorization by notifying Dr. Slotnick's office/ and/or the RELEASING PARTY ABOVE **in writing** of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
3. My purpose/use of the information is for _____ .
4. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signature.

Official Use Only

_____	_____	_____
Received	**Processed By**	**Date Processed**