Authorization to Release Medical Records/ Information

Patient's Name:_____ Date of Birth:_____

Physician/ Organization to provide records: _____

Fax number: _____

Person to receive records:

Paula Jonson-Wyatt, OD, FCOVD
Johnson Vision Development Center
1012 Greystone Square
Jackson, TN 38305

Fax# 731-660-0688

Release these records:

- All medical records at this facility
- Last Comprehensive Eye Exam
- Glasses/ Contact Lens Prescription

I authorize the professional office of my doctor named above to release health information or receive health information identifying me or my child (including if applicable, information about substance abuse treatment, and information about mental health services) under the following terms and conditions: 1.It is completely your decision whether to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization form. 2.If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person. 3.When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY AND AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Name (print):_____

Patient's Signature/ Authorized Signatures: _____

Relationship to Patient: _____Date:_____

JOHNSON VISION DEVELOPMENT CENTER