Dr. Philip L. Nicholson, O.D., Visual Learning Center

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PATIENT AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete all items. An incomplete request may result in delay of release of records. Please Print

Name of Patient Date of Birth

Street Address City State Zip Phone

Maiden Name or other name used for records

I hereby authorize:

Name of person or place records are requested from Phone #

Address of person or place records are requested from Fax #

To release to: **Please send via** ☐ Email ☐ Fax

Dr. Philip Nicholson, O.D. **301-570-4611**

Name of person or place records are to be sent to Phone #

17904 Georgia Avenue, Suite 203, Olney, MD 20832 **301-570-4611**

Address of person or place records are to be sent to Fax #

The following information from my records:

- ☐ Last Exam, including most recent tests (VF, OCT, PACH, ETC…)
- ☐ Records from time period ______________________________to_________________________________
- ☐ Discuss verbally my child's academic performance
- ☐ Copies of all psycho-educational testing reports
- ☐ Patient personal use
- ☐ Other ____

This authorization will expire one year from the date listed below or on ____/____/________ or occurrence of specified event at which time this authorization to use or disclose the identified health information expires, but no later than **one year** from the date listed below.

I, the undersigned, have read the above and authorize the disclosure of such health information as described herein. I understand that treatment is not conditioned upon the execution of this authorization.
I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
I understand that I may revoke this authorization at any time by providing a written notice to the person identified below except to the extent that action has been taken in reliance upon it or except as otherwise stated in Dr. Nicholson's Notice of Privacy Practices by mailing or hand-delivering written notification to Dr. Nicholson.

Signature of Patient or Patient Representative **Date**

Printed Name of Patient Representative and Relationship Patient Representative Address and Phone Number