TRI-COUNTY VISION ASSOCIATES, LLC (860) 423-2565
16 Walnut St - Willimantic, CT 06226 fax (860) 423-8058

Patient Name: _____ Date of Birth: _____

I authorize the use and/or disclosure of my protected health information as described below.

I am authorizing the following office to release the information requested below.

Tri-County Vision Assoc.
16 Walnut Street
Willimantic, CT. 06226

I wish to release the following (check all that apply):

- ☐ Most recent eye exam
- ☐ Most recent eye test
- ☐ Office notes pertaining to: _____
- ☐ Entire Medical Record
- ☐ Other (elaborate): _____

The purpose of this release is because:

- ☐ I am changing physicians
- ☐ For coordination of care with my other doctor
- ☐ I am moving and not sure of a new physician
- ☐ I would just like a copy for my records
- ☐ Other (pls specify): _____

Send the requested information to:

Office Name: _____ Office Phone: _____
Doctor Name: _____ Office Fax: _____
Address: _____
_____
_____

This authorization will expire 180 days from the date signed. I can revoke this authorization anytime in writing, however if the requested information has been already disclosed I realize it cannot be taken back. I have reviewed and I understand this authorization. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under federal law. I also understand that there may be a fee of $0.65 per page per copy.

_____ _____
Signature of Patient or Representative Relationship (if signed by representative)

_____

Date Signed