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/company to release the information I am requesting:

Name of Office: _____
Physician Name: _____
Address: _____
_____
Telephone: _____ Fax: _____

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

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

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 (be specific):_____

Please send the requested information to:

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

Office (860) 423-2565
Fax (860) 423-8058

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.

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

Date Signed