

Nashville Vision Associates, PLC
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Authorization for Release of Medical Information

Patient Name: _____
Patient Date of Birth: _____
Patient Phone Number: _____

Physician who is releasing information: _____
Fax: _____ Phone: _____

Person or Place to whom information is to be released:

Name: _____
Address: _____
City, State & ZIP: _____
Fax: _____ Phone: _____

Information Type Requested: _____
Dates of Treatment: _____

Patient Signature: _____
Today's Date: _____

Our notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect, and copy protected health care information used to make decisions about them. Nashville Vision Associates may limit access to information generated only by this practice. This form is to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. A copy of the Full Notice is available at your request.