Information For Your Health Care Team – Patient Permission

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I grant permission for the transfer of information regarding the vision and learning-related vision problems of the below patient from Clarendon Vision Development Center to any below designated doctors and providers on the patient's care team.

I also authorize any below designated doctors or care providers, under which the patient is receiving care, to provide information to Clarendon Vision Development Center as requested.

I understand that the exchange of this information is being conducted to assure that all professionals working with the patient have access to data which might affect treatment modes.

Patient Name: _____ Date Authorized: _____

Parent/Guardian Name: _____ Signature: _____

Please list designated doctors and members of the patient's care team below: (As applicable, Primary Care Provider, Pediatrician, Neurologist, Neuropsychologist, Occupational Therapist (OT), Physical Therapist (PT), Audiologist, TBI Specialist, Reading Tutor/Specialist)

First/Last Name: _____ Specialty/Profession: _____

Address: _____

Phone: _____ Fax: _____

First/Last Name: _____ Specialty/Profession: _____

Address: _____

Phone: _____ Fax: _____

First/Last Name: _____ Specialty/Profession: _____

Address: _____

Phone: _____ Fax: _____

First/Last Name: _____ Specialty/Profession: _____

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