Acct: #_____

New England VISION

HOME OF VERMONT EYE LASER

# Request for Release of Protected Health Information

**Explanation:** If there is anyone you want us to be able to talk with regarding your PHI (Protected Health Information), you need to fill out this form or we will not be able to speak with them. This information could include questions on appointments, medications, exam results, etc. This is because of the Privacy Act.

Please note: You do not need to put your doctor's name here, as information shared between doctors is covered under the Privacy Act. If there is no one you wish us to talk with about your PHI, please mark N/A (Not Applicable) and sign this form.

I authorize the release of my PHI (Protected Health Information) to:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I agree there are no restrictions to the disclosure of my PHI to the above named.

Please restrict the disclosure of my PHI to the following information:

_____

_____

I have received or been offered a copy of New England Vision / Vermont Eye Laser's Notice of Privacy Practices.

Patient Signature: _____ Date: _____