Release of Information

By signing this authorization, I agree that **NovaVision, Inc.** may disclose my individually identifiable health care information, including my therapy progress and related medical history, to my **Physician and associated professional staff**.

In addition to my prescribing physician, I authorize NovaVision, Inc. to disclose my therapy progress and related medical history to the **following person(s)**.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

1. I understand my prescribing physician will have access to regular status reports of my therapy progress.
2. I understand I have the right to know what has been disclosed and may request this information.
3. I understand I may revoke this authorization at any time by notifying NovaVision, Inc. in writing. Revocation will not apply to any actions taken before receipt of the revocation, which must be submitted to NovaVision Patient Services at: **NovaVision, Inc.,951 Broken Sound Parkway, Suite 320, Boca Raton, FL 33487.**
4. I understand this authorization will continue following completion of my therapy only to the extent of the results and reports on my completed therapy.
5. I authorize the release of my confidential protected health information, as described above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by applicable laws which prohibit redisclosure or limit the use and/or disclosure of my confidential protected health information. My treatment, payment, enrollment and eligibility are not conditioned on signing this authorization.

I,_____, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ _____

Signature of Patient or Legal Guardian ***Date***

_____ _____

Printed Name of Patient or Legal Guardian ***Relationship to Patient***