

Nashville Vision Associates, PLC

Comprehensive Eye Care

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Consent For Release of Medical Records

I hereby authorize

- Nashville Vision Associates
- Doctor/Hospital _____

to release my records to

- Nashville Vision Associates
- Doctor /Hospital _____
 - At this Address: _____
 - _____
- Fax number: _____

(Patient records will only be faxed to other physicians under **emergent** circumstances **and** at the discretion of Nashville Vision Associates.)

I would like my records released to me:

- I will pick them up.
- Mail them to my home address

Include these dates of service: _____.

My records should be under the following:

Name: _____

Address: _____

Date of Birth: _____ **Soc Sec #** _____

Signed: _____ **Date:** _____

***This form must be completely filled out in order to process the request.**

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 provided to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA). A copy of the Full Notice is available at your request.