ACHIEVE
VISION CENTER

A Service of
ACHIEVE OCCUPATIONAL THERAPY SOLUTIONS, INC.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, _____, hereby authorize
Patient Name Date of Birth

Name of Office: _____

Phone #: _____ Fax #: _____

To disclose the following information to **Achieve Vision Center**

- ☐ All Patient Medical Records
- ☐ All Evaluation Reports

PLEASE FAX THESE RECORDS TO 770-509-2233

I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law. I understand that I may revoke this authorization at any time by notifying the person/office providing the information in writing, except to the extent that:

A. Action had been taken in reliance on this authorization; or

B. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

I understand that my medical records are strictly confidential. No information will be given to others without my written permission.

_____ _____
Signature of patient or patient's representative Date

_____
Print Name

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