



Linda Dejmek O.D., FOVDR  
Neuro-Developmental  
Optometrist

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Vision Therapy Centers, SC

1401 McMahon Dr., Suite 100  
Neenah, WI 54956

Office: 920-722-2020  
Fax: 920-722-2022

email: info@abseevision.com

**PATIENT:**

\_\_\_\_\_  
Name of Patient/Previous Names

\_\_\_\_\_  
Birth Date/Medical Record Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

**AUTHORIZES:**

**RELEASE OF PROTECTED HEALTH INFORMATION TO:**

\_\_\_\_\_  
Name of Health Care Provider/Plan/Other

*A B See Vision Therapy Centers, SC—Dr. Linda Dejmek*

\_\_\_\_\_  
Name of Health Care Provider/Plan/Other

\_\_\_\_\_  
Street Address

*1401 McMahon Drive, Suite 100*

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

*Neenah, WI 54956*

\_\_\_\_\_  
City, State, Zip Code

**INFORMATION TO BE RELEASED:**

Date of Service

- Visual Fields \_\_\_\_\_
- Contact Lens info. \_\_\_\_\_
- Spectacle info. \_\_\_\_\_
- Last 2 years of comprehensive examination \_\_\_\_\_

**THIS DISCLOSURE IS BEING MADE FOR THE FOLLOWING PURPOSE(S):**

- Vision Therapy
- Payment Process/Insurance/Billing Difficulties
- At the Request of an Individual
- Other (comments) \_\_\_\_\_

REDISCLASURE NOTICE: I understand that if the person(s) and /or organization listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

**YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION**

**Right to Inspect or Copy the Health Information to Be Used or Disclosed** - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting A B See Vision Therapy Centers. **Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, I will be provided with a copy of it. **Right to Refuse to Sign This Authorization** - I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Revoke This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact A B See Vision Therapy Centers. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. A B See Vision Therapy Centers reserve the right to charge for the copying of medical records as permitted by law.

**Expiration Date:** This authorization is good until the following date(s) \_\_\_\_\_ or for one year from the date signed. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

**SIGNATURE PATIENT/LEGAL REP:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(If signed by other than patient, state relationship and authority to do so.)

- Parent
- Guardian
- POA for Healthcare
- Spouse/Adult Family Member of Deceased Patient

Patient is:  Minor  Incompetent  Disabled  Deceased