CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION

Completion of this form authorizes the release of information described in the section below called "Specific Description of Records Authorized for Release". The person (record subject) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication / somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances.

Name – Person Whose Records Will Be Released:

Address:

City, State, Zip Code:

Date of Birth:

Name and Address – Doctor's Office I Authorize to Release Information:

Information May Be Released To:
Name: Amy Wurf, Low Vision Therapist

Organization: Wisconsin Council of the Blind & Visually Impaired

Address: 754 Williamson St.

City, State, Zip Code: Madison, WI 53703

Specific Description of Records Authorized for Release:

Please fax records to: 608-255-3301, attn: Amy Wurf
Phone contact: 608-237-8107

Copy of most recent eye examination, including acuities, diagnosis, and any future procedures planned

Purpose of Need for Release of Information:

Assist in providing comprehensive low vision evaluation, training with adaptive equipment, and other related vision services

Understandings:

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility.
- The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.
- I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information.
- Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Authorization expires after the following action takes place: Conclusion of low vision evaluation and training

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

SIGNATURE - Person Whose Records Will be Released (Record Subject)		**Date Signed**
SIGNATURE - Other Person Legally Authorized to Consent to Disclosure	Title or Relationship to Record Subject	**Date Signed**