Nashville Vision Associates, PLC

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Phone: 615-297-6591
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Authorization for Release of Medical Information

Patient Name:____
Patient Date of Birth:____
Patient Phone Number:____

Physician who is releasing information:__________________________
Fax:_________________________ Phone:_________________________

Person or Place to whom information is to be released:
Name:____
Address:____
City, State & ZIP:____
Fax:_________________________ Phone:_________________________

Information Type Requested:___________________________________
Dates of Treatment:____

Patient Signature:____
Today's Date:____

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