NORTHERN VALLEY
Eye Care INC.

802-524-9561
Fax: 802-524-6060
www.nveyecare.net

128 Fisher Pond Road
St. Albans, VT 05478

Steven J. St. Marie, O.D.
Laura L. Werner, O.D.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

_____ _____
Patient Name **Date of Birth**

I hereby authorize _____ to:
_____ obtain my information from:
_____ release my information to:

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone# Fax #

_____ _____
Patient's Signature **Date**

_____ _____
Signature of Legal Representative/Relationship to Patient **Date**

Revocation Process: I understand that I must place my request in writing; I can revoke this authorization at any time. However, I understand that a healthcare organization cannot take back information that has already been released in response to this Authorization. I understand that the revocation of this Authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy.

*By state law, fees may be charged for making copies. Our standard fees are as follows: We are happy to provide up to 4 pages of copies at no charge. Beyond that, .50 per page will charged thereafter. You may also be charged for postage if you ask that the records be mailed to you or a provider.
**HIPAA allows 30 days for a provider to respond to your request for records.