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: _____ DOB: _____

I hereby authorize Northern Valley Eye Care, Inc. to: ☐ Obtain ☐ Release my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions to/from:

_____
Healthcare Provider/Business Name

_____
Address City State Zip

_____
Phone Fax

Please detail the reason information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write "at my request."

_____

_____

Duration of Authorization:

☐ All past, present, and future periods ☐ The date of the signature until the following event:

From_____to_____

Do you wish to withdraw as a patient of Northern Valley Eye Care when the your records have been transferred? ☐ Yes ☐ No

_____
Patient 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 the 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 be 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.