# Authorization For Use/Disclosure Of Health Information

Name Date of Birth

Former Vision Care Provider

I voluntarily authorize and direct my former vision care provider to send my vision records/information to the recipient that I have identified below.

Recipient: Name of person or class of persons to whom my vision care provider may disclose my vision information to:

**Blink Vision by Veatch**
**Dr. Ryan Veatch**
**660 W. Cherry Street**
**North Liberty, IA 52317**

Records may be sent by email to: blink@blinkvision.com or faxed to 319.665.2757

Purpose: I understand that the specific purpose of this Authorization is at the request of the patient.

Information to be disclosed: This authorization permits the above provider to disclose all of my health information that the provider has in his or her possession, including information relating to any medical history, vision history, mental or physical condition and any treatment received by me.

Signature Date

Fax to: