NOTICE OF PRIVACY PRACTICES AND DISCLOSURE AUTHORIZATION OF PROTECTED HEALTH INFORMATION

By signing this document, you acknowledge that you have received or been offered a copy of InSight Vision Therapy's Notice of Privacy Practices, stating that your personal health information will not be given to any unauthorized person.

Under the Health Insurance Portability and Accountability Act policies, a patient may authorize the release of his or her protected information to specific persons or entities. In order to discuss your protected health information with anyone other than yourself, we need your authorization to do so.

Please check one box below:

- ☐ **I do NOT want my protected health information released to anyone but myself.**
- ☐ **I authorize InSight Vision Therapy to disclose my protected health information to the following individual(s):**

Name	Relationship to patient	Billing Information	Medical Information
		☐	☐
		☐	☐
		☐	☐
		☐	☐

I understand that I may revoke this authorization at any time by giving written notice to:

InSight Vision Therapy, 814 East Jackson Street Suite A, Medford, Oregon 97504.

I understand that revocation of this authorization will not affect any action InSight Vision Therapy took in reliance of this authorization before the above named entity received my written notice of revocation.

_____ _____
Patient Name (please print) Patient Date of Birth

_____ _____
Patient Signature Today's Date

- ☐ **I am the patient's parent/guardian.**

_____ _____
Parent/Guardian Name (please print) Relationship to Patient

_____ _____
Parent/Guardian Signature Today's Date