Community
Low Vision
Center

Release of Authorization

Effective ________________ [date], I, ____________________

________________________ [name], hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

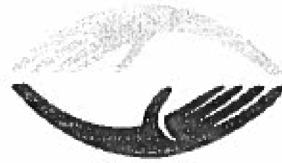
I authorize the Community Low Vision Center to receive, use or disclose my health information relevant to vision health. This may include eye reports and/or medical records. Authorized protected health information will only be use and/or disclosed for the purpose of thorough and accurate completion of low vision screening on your behalf.

I understand that this authorization is voluntary, and that I may refuse to sign this authorization. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. The revocation will not be valid, however, if the Community Low Vision Center has taken action in reliance on this authorization.

This authorization expires in one year's time upon signing.

Signature ____

Date Signed ______________________________________



Community
Low Vision
Center

Optional Photography and Publishing Consent

Literacy

For guardian of child I, ________________________, am the parent or legal guardian of _________________________ and agree to allow photographs of ___________________ taken by The Community Low Vision Center to be published in any format for use to further promote the Focus on Literacy program at IFB Solutions. This release covers photographs made while at the Low Vision clinic.

Signed___________________________________

Date______________________________

For adult

I, ____________________, agree to allow photographs of me taken by The Community Low Vision Center to be published in any format for use to further promote the Focus on Literacy program and/or Sight recycled program at IFB Solutions. This release covers photographs made while at the Low Vision clinic.

Signed_____________________________ Date_________________________