Justine Simon Bailey, OD, FOVDR
San Diego Optometric Vision Therapy
5230 Carroll Canyon Rd, Suite 314, San Diego, CA 92121
Phone/Voicemail/Text/Fax: (858) 433-4060
sdvisiontherapy.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Requesting information: ☐ **FROM** ☐ **TO**

☐ **FROM** ☐ **TO**

Office/Provider Name: _____

Address: _____

Phone: _____

Fax/email: _____

Dr. Justine Simon Bailey, OD, FOVDR
Phone/Voicemail/Text: (858) 433-4060
Fax: (858) 433-4060
Email: dr.simonbailey@gmail.com

The professional offices named above are authorized to release health information identifying the patient named above under the following terms:

1. Information to be released:
   - ☐ Most recent examination
   - ☐ All Records
   - ☐ Contact Lens/Glasses Information
   - ☐ Other _____

   This information will be released to/from Dr. Justine Simon Bailey, OD, FOVDR.

2. Expiration Date (usually one year from today) _____

3. The purpose of this release is to obtain/provide information important to your treatment. It is your decision whether to sign this form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. If you want to revoke your authorization, send a written or electronic note to the office telling us that your authorization is revoked.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above. I understand I am entitled to a copy of this form.

_____ _____
Signature Date

If signing as a representative of the patient, describe the relationship to patient:

_____ _____
Print Name Relationship to Patient