Dynamic
VISION THERAPY
PLLC

RELEASE OF INFORMATION

It is often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Please sign below to authorize the release of information.

I agree to permit information from, or copies of my examination records to be exchanged with other health care providers or provided to insurance carriers upon their written request or upon the recommendation of the Dynamic Vision Therapy, PLLC, when it is necessary for the treatment of my visual condition, or for the processing of insurance claims. This authorization shall be valid for the duration of treatment.

_____ _____

Signature or Authorized Representative Date

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