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Authorization to Release Confidential Information

Name of Patient:

Date of Birth:

Please choose ONE of the following options:

☐ **Transfer my records to the Prevention of Blindness Society Vision Rehabilitation Clinic**

☐ **Send a copy of my records to me at the address on file and do not transfer my records**

☐ **Do not transfer my records but fax a copy of my records to the following practice/doctor's fax number:**

Signature of Patient or Power of Attorney:

_____ **Date:** _____

Printed name of Patient or Power of Attorney:

_____ **Date:** _____