Steven Squillace, O.D.
48 South Road, Unit #8
P.O. Box 801
Somers, CT 06071

Somers Vision Clinic

Telephone: 860-763-4733
Fax: 860-749-6795
somersvision@gmail.com
www.somersvisionclinic.com

Patient name_____ Date_____

Date of birth_____Phone _____e-mail_____

☐ Please allow the doctor listed at the bottom of this page to mail the following records to us at P.O. Box 801:

☐ Please allow us to send the following the records to the doctor listed at the bottom of this page:

☐ Medical Records ☐ Contact Lens Parameters ☐ Spectacle Rx ☐ Other _____

Release of Privileged Information: If your medical record contains any of the following types of information it will not be released unless you check the type of information that may be disclosed to the health provider:

___Alcohol/Drug Abuse ___Sexually Transmitted Diseases ___Psych or Substance Abuse Program

**Release of HIV/AIDS Information:* I hereby authorize release of my health information pertaining to HIV/AIDS related testing, diagnosis and/or treatment.

Signature_____ Date_____

Individual Rights:

- I have the right to revoke this authorization at any time in person or by mail.
- If I revoke this authorization, I must do so in writing to the attention of the Health Information Department of Somers Vision Clinic.
- My right to revoke does not apply to information already released by this authorization.
- I need not sign this form in order to ensure healthcare treatment, payment, enrollment or eligibility of benefits from my health insurance.
- The information released on the basis of this authorization may be subject to re-disclosure by the recipient (e.g., doctor to specialist or lab/imaging department).

_____ _____ _____
Signature of Patient or Guardian* Print Name of Patient Or Guardian Date

*If this request is being signed by an individual's personal representative, please state the basis for the representative's authority:_____(e.g., state law, court order, etc.)

Expiration date: This authorization will expire in one year unless revoked or otherwise specified to expire on the following date _____,

Doctor's name _____Address _____

City _____State _____ Zip _____

Phone _____ Fax _____