AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name_____

Patient DOB_____

I hereby grant permission the following agencies to release all records pertaining to the patient's relevant health history, diagnosis, and treatment documentation to InVision, LLC:

1. Agency Name_____

   Address_____

   Telephone_____ Fax_____

2. Agency Name_____

   Address_____

   Telephone_____ Fax_____

Signature_____ Date_____
Patient or Guardian/Agent

2715 Broadbent Pkwy NE, Suite D • Albuquerque, NM 87107
• phone 505-341-2020 • fax 505-286-6152 • **www.invisionvt.com**