CENTER FOR THE VISUALLY IMPAIRED

Authorization To Release Information

I hereby agree and consent for any agency that has information of a medical, social, or psychological nature concerning my condition to release this information to the Center for the Visually Impaired (CVI). I also agree and consent for CVI to, in turn, release information concerning me that is of a medical, social, and/or psychological nature as needed by other cooperating agencies. Material released may or may not contain information related to infectious disease status. All information will only be used by professional persons for the purpose of aiding my rehabilitation. Unless indicated, this release will be valid for 12 months from the date below.

Signature _____

Print Name _____

Date _____

Witness _____

739 West Peachtree St. NW • Atlanta, GA 30308 • Ph: 404.875.9011 • Fax: 404-875-4568

Accredited Member, National Accreditation Council United Way Agency