INSIGHT
Promoting Independence and Opportunities for People with Vision Loss.

Please have parent's complete 2 separate releases for Functional Vision Assessments scheduled at Insight.

1. For Insight to Obtain and Release information from/to the EI Agency and,
2. For Insight to Obtain and Release information from/to the Child's Ophthalmologist

Child's Name: DOB: / / ID #

Child's Address:

Please provide one consent per recipient. Initial INSIGHT referral requires "obtain" and "release" for EI provider and Ophthalmologist.

I hereby authorize Insight to: ☐ Obtain from and/or ☐ Release to

EI Program _____

☐ Ophthalmologist: _____

Address:

Information to be released includes (Check all for initial INSIGHT referral):

☐ Ophthalmological Medical Records

☐ Other (specify)

Records are being shared for the purposes of service coordination and treatment planning.

I understand that my child's records are protected under RI general law 4-6-12. All information released or received as a result of this consent shall not be furthered relayed in any way to any person or organization outside INSIGHT without additional written consent.

I understand that if my child's ophthalmological information indicates a diagnosis consistent with the legal definition of blindness, that information will be reported to RI Services for the Blind and Visually Impaired as required by RI mandatory reporting general law # 40-9-15.

This authorization will expire one year from date of signature. I understand that I may revoke this authorization in writing at any time.

Signature of Parent or Guardian: Date / /

Fax or Mail to:
INSIGHT
43 Jefferson Blvd.
Warwick, RI 02888
Phone: 401-9413322
Fax: 401-941-3356