



Center Of Vision Enhancement

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www.covemerced.org
FEIN # 68-0670036

Resource Center for Blindness & Low Vision
"We may lack sight, but we have vision."

Authorization for the Release of Information

I understand that Center of Vision Enhancement (COVE) has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow COVE to release some of my personal information to certain individuals or agencies.

I, _____, authorize COVE to share information with:

Programs and Services related to my low vision or blindness; or only

Agency Name: _____

Agency Name: _____

Information should be limited to:

Personal Demographic Information

Knowledge of Disability/Abilities

Educational and Vocational Goals

Rehabilitation Services

The information may be shared:

in person by phone by fax by mail by e-mail

I understand that I do not have to sign a release form. I do not have to allow COVE to share my information. Signing a release form is completely voluntary. I also understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Signature: _____

Date: _____