REQUEST FOR RELEASE OF MEDICAL RECORDS
TO PROVISION EYE CENTER

I hereby authorize you to release my medical records and <u>all</u> testing including but not limited to visual fields/OCT's/ and Ascans to:

Provision Eye Center
Scott Durrett, MD Robert Daddario, OD
1191 Jacaranda Blvd.
Venice, FL 34292
(941)493-0311 (941)492-4655

Requested from:

Physician Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax:_____

All medical records, including, but not limited to information regarding any treatment, hospitalization, and/or outpatient care including psychological/psychiatric care, sexually transmitted diseases, drug/alcohol abuse and rehabilitation, Acquired Immune Deficiency Syndrome (AIDS), tests for Human Immunodeficiency Virus (HIV) Antibody or Antigen.

(PLEASE CROSS OUT ANY INFORMATION THAT YOU DO NOT WANT INCLUDED IN THIS RELEASE)

This release of medical records expires six (6) months from the date below.

Patient:_____

Social Security Number:_____ Date of Birth:_____

_____
Signature of patient or legally authorized representative Date