PROVISION LASER EYE CENTER

Request for release of medical records from ProVision Laser Eye Center

Do you have questions? Please feel free to contact us at **(941) 493-0311**

I hereby authorize you to release my medical records to:

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

I request the following records:

( ) All _____ Test(s) _____ Specific Date of Service

( ) I would like to pick up my records when they are ready

( ) I would like to have my records mailed when they are ready

( ) I will be returning to this practice

( ) I will not be returning to this practice

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

Patient Name: _____

Social Security Number: _____ **Date of birth:** _____

_____ _____

Signature of patient or legally authorized representative Date