

Roger J. Meyer, M.D.

*Board Certified
Retina Fellowship Trained
Macular Degeneration
Diabetic Eye Care • Glaucoma*



David J. O'Brien, M.D.

*Board Certified
Fellowship Trained Refractive Surgeon
General Ophthalmology • Glaucoma
Eyelid Surgery • Aesthetics*

James E. Copeland, Jr., M.D.

*Board Certified
Honorary Staff*

Paul V. Minotty, M.D.

*Board Certified • Cataract Surgery
General Ophthalmology • Glaucoma*

Stephen M. Tate, M.D.

*Board Certified • Cataract Surgery
General Ophthalmology • Glaucoma*

**RECORD'S DEPARTMENT FAX: (772) 257-8705
AUTHORIZATION FOR RELEASE OF INFORMATION**

LAST NAME, FIRST NAME, MIDDLE INITIAL

DATE OF BIRTH

SOCIAL SECURITY

HOME PHONE

WORK PHONE

CURRENT MAILING ADDRESS

CITY, STATE, ZIP

I HEREBY AUTHORIZE NEW VISION EYE CENTER TO:

_____ RELEASE MY MEDICAL RECORDS TO:

_____ OBTAIN MY MEDICAL RECORDS FROM:

DOCTOR OR FACILITY:

STREET ADDRESS:

CITY/STATE/ZIP:

PHONE/FAX NUMBER:

INFORMATION TO BE:

_____ MAILED _____ FAXED _____ PICK UP ON: _____

THIS AUTHORIZATION WILL EXPIRE IN ONE (1) YEAR FROM THE DATE OF THE SIGNATURE OR UNTIL IT IS REVOKED IN WRITING TO AN AUTHORIZED EMPLOYEE OF THE NEW VISION EYE CENTER.

I HEREBY RELEASE NEW VISION EYE CENTER AND ITS EMPLOYEES FROM ANY AND ALL LIABILITY THAT MAY ARISE FROM THE RELEASE OF INFORMATION AS I HAVE DIRECTED.

PATIENT SIGNATURE OR
PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE SIGNATURE

DATE