NEW VISION EYE CENTER

1055 37th Place | Vero Beach, FL 32960
T: 772.257.8700 | F: 772.257.8705
NewVisionEyeCenter.com |

Authorization For Release Of Information

Record's Department Fax: (772) 257-8705

Last Name, First Name, Middle Initial _____ Date of Birth _____

I hereby authorize New Vision Eye Center to:

◯ Release my medical records to: _____

◯ Obtain my medical records from: _____

All Records ◯ Last 12 Months ◯

Please include all exams, visual fields, OCT's and any other imaging studies

Doctor or Facility: _____

Street Address: _____

City/State/Zip: _____

Phone/Fax Number: _____

Information to be: Mailed ◯ Faxed ◯ Picked up ◯ Date: _____

This authorization will expire in one (1) year from the date of the signature or will remain in effect until it is revoked in writing to an authorized employee of 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 or Authorized Representative _____ Date _____