Premier Eye Associates

10006 Wellness Way, STE C-100, Orlando, FL 32832 PH (407) 737-7500 Fax (407)380-2872

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize Premier Eye Associates to release copies of my medical records to the following:

Provider	Phone	Fax

Please release copies of:

- Office Notes
- Visual Fields
- Retinal Scans
- Corneal Topography
- Laboratory Reports
- Radiology Reports
- Pathology Reports
- Other_____

For the purpose of: ○ Continued Treatment ○ Personal Records

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization.

Patients are responsible for Medical Records $1.00 per page. Charge will be waived if Medical Records are faxed to a physician's office.

_____ _____

(Patient/Parent/Guardian Signature) Date of Authorization (MM/DD/YYYY)

_____ _____

Print Patient's Name Date of Birth (MM/DD/YYYY)

_____ _____

Relationship Patient's Social Security Number