Authorization to Release / Obtain Health Information

[_] Permission to send Medical Records to: [_] Request Medical Records from

Name _____

Address _____

City/State _____

Telephone _____

I authorize this information to be faxed. Number: _____

For Healthcare Covering the Period(s) [ ] All or From: _____ To: _____

I understand that specific information to be released may include any illness or injury, medical history, consultation, prescription or treatment, and/or copies of all hospital and medical records, including testing, photography, lab results, prescriptions, operative reports, and letters. This infomation may include AIDS or HIV, alcohol and/or drug abuse, and mental health.

Today's date _____Unless otherwise indicated, this authorization will expire (12) months from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purpose stated above.

I understand that there may be a fee for preparing and furnishing this information.

_____	_____	_____
Signature of Patient/Legal Representative	Patient Name (Print)	Date of Birth

Florida Eye Associates Physicians

Vrinda Hershberger, MD	Rohit Parihar, MD	Payman Haft, MD	
Tracy Ravin, MD	Yue Michelle Wang, MD	Ralph Paylor, MD	
Daniel Brown, OD	Victoria Dixon, OD	David Weiser, MD	
L. Neal Freeman, MD	Jason Ross, MD	Deborah Consbruck, OD	Initial_____

FLORIDA EYE ASSOCIATES
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