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

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Patient Phone _____

I hereby authorize New Vision Eye Center to: *(CHECK ONE)*

☐ Release Medical Records ☐ Obtain Medical Records

Doctor and/or Facility _____

Street Address _____ City/State/Zip _____

Phone _____ Fax _____

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

☐ Last 12 Months ☐ Last Office Visit

Information to be: ☐ Mailed ☐ Faxed ☐ Picked Up Date: _____

This authorization will expire one (1) year from the date of 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.

Signature of Patient or Authorized Representative _____ Date _____

Records Department: **Fax:** (772)257-8705 **Email:** reception@newvisioneye.com