**Request for Release of Medical Records**

Patient Name: Date of Birth:

I, , hereby authorize the doctors and staff at Advanced Eyecare

(Patient’s Name (or Parent/Legal Guardian)

to release/obtain records concerning my eye health. I understand that the specific type of information disclosed/received may include a detailed report of examinations, treatment provided, testing and any other records that pertain to my eye information.

Please select one:

­ Records given directly to me (or parent/guardian, if patient is a minor)

Records to be sent to Physician/Practice (complete below)

Records to be sent from prior Physician/Practice to Advanced Eyecare (complete below)

Name of Physician/Practice:

Address:

Telephone Number: Fax Number:

Email Address:

This authorization is effective until I cancel this consent. I understand that I may revoke or terminate this authorization by submitting a request in writing to: Advanced Eyecare 322 Dewey Street, Bennington, VT 05201

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**Date: PRINT** Patient Name:

**SIGN** Patient Name:

(If Child, signature of Parent or Legal Guardian)

**Office Use Only:** Date Request Received: Date Records Sent:

Sent By:

Delivery Method of Records: Mail Fax Email Other:

Date Release Scanned into Patient’s Chart:

Return Release to:

322 Dewey Street 77 Hospital Ave., Suite 110 5222 Main Street

Bennington, VT 05201 North Adams, MA 01247 Manchester, VT 05255

Fax: (802) 447-1500 Fax: (413) 664-7349 Fax: (802) 366-8045