

This form provides your authorization to release your medical records from any physician to Newsom Eye and Laser Center. Print this form and complete it in its entirety. FAX, mail or deliver the completed form to any Newsom Eye location.

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize and request you to release the complete history records in your possession, concerning my illness and/or treatment to include any and all records concerning HIV virus.

I understand that:

1 I have the right to revoke this authorization at any time in writing and to present my written revocation to the Newsom Eye & Laser Center Medical Records Department. I understand that revocation does not apply to information that has already been released in response to this authorization.

2 Once the information is disclosed pursuant to this authorization, the recipient may disclose it and the information may not be protected by federal privacy regulations.

3 I do not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

PATIENT NAME: *please print* _____

SOCIAL SECURITY#: _____ DATE OF BIRTH: _____

TO BE RELEASED FROM:

NAME *please print* _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE#: _____ FAX#: _____

TO BE RELEASED TO:

T. Hunter Newsom, MD / David Garruto, MD / Vinita Srivastava, MD / Kendra DeAngelis, MD / Fayssal El-Jabali, DO / Eric Fazio, OD / Mitchell Petit, OD / Jessica Forde, OD / Aimee Grimm, OD / Daniel Ochs, Resident OD

NEWSOM EYE AND LASER CENTER

SOUTH TAMPA: 113 S. Armenia Ave, Tampa, FL 33609 **FAX:** (813) 876-8934

CARROLLWOOD: 13904 N Dale Mabry Hwy, Suite 200, Tampa, FL 33618 **FAX:** (813) 908-2133

SEBRING: 4211 US Hwy 27 N, Sebring, FL 33870 **FAX:** (863) 385-1233

WHEN WILL THIS AUTHORIZATION EXPIRE? (CHECK ONE BOX) Note: If I fail to list an expiration date or event below, this authorization will expire one year from the date signed, unless revoked prior to that date.

- No expiration Upon my death
- On the following date ____/____/____ (MM/DD/YYYY) Upon my written revocation
- On the following event: _____

PATIENT'S SIGNATURE: _____ DATE: _____

WITNESS: _____