

**This form provides your authorization to release your medical records from Newsom Eye and Laser Center to any physician. 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.

**4** There is a fee of \$1.00 per page for the first 25 pages of medical records released, and \$0.25 per page for any additional pages.

PATIENT NAME: *please print* \_\_\_\_\_

SOCIAL SECURITY#: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

REASON FOR RECORDS REQUEST: \_\_\_\_\_

**TO BE RELEASED FROM:**

T. Hunter Newsom, MD / David Garruto, MD / Matthew Donovan, MD / Arian Moses, MD / Eric Areiter, MD /  
James Jachimowicz, MD / Kayla Unsell, MD / Brian Szabo, DO /  
Eric Fazio, OD / Jessica Mark, OD / Daniel Ochs, OD / Laura Vandenberg, OD / Lauren Wasikowski, OD / Michael Chermak, 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  
**PINELLAS:** 3615 N McMullen Booth Rd., Bldg. A-1, Clearwater, FL 33761 **FAX:** (727) 494-0704  
**BROOKSVILLE:** 14543 Cortez Blvd. #6065, Brooksville, FL 34613 **FAX:** (352) 596-1997

**TO BE RELEASED TO:**

NAME (please print) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PHONE #: \_\_\_\_\_ FAX#: \_\_\_\_\_

**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.

- |  |   |
|--|---|
| <input type="checkbox"/> No expiration                                     | <input type="checkbox"/> Upon my death              |
| <input type="checkbox"/> On the following date ____/____/____ (MM/DD/YYYY) | <input type="checkbox"/> Upon my written revocation |
| <input type="checkbox"/> On the following event: _____                     |   |

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_