NEWSOMEYE
You deserve NEWSOM EYES!

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 / 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., 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

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:_____