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* _____ DATE OF BIRTH _____ SOCIAL SECURITY # _____

TO BE RELEASED FROM:

NAME *please print* _____

ADDRESS _____

CITY, STATE, ZIP _____ PHONE # _____ FAX # _____

TO BE RELEASED TO:

- T. Hunter Newsom, MD
- William A. Newsom, MD
- Brian Szabo, DO
- B. David Garruto, MD
- Akaanksh Shetty, MD
- Eric Fazio, OD
- Jessica Mark, OD
- Daniel Ochs, OD
- Laura Vandenberg, OD
- Marissa Cruz, OD

NEWSOM EYE AND LASER CENTER

SEBRING	4211 US Highway 27 N, Sebring, FL 33870	FAX: **(863) 385-1233**
CARROLLWOOD	13904 N Dale Mabry Hwy, Suite 200, Tampa, FL 33618	FAX: **(813) 908-2133**
SOUTH TAMPA	113 S Armenia Ave, Tampa, FL 33609	FAX: **(813) 876-8934**
BROOKSVILLE	14543 Cortez Blvd, Brooksville, FL 34613	FAX: **(352) 596-1997**
GAINESVILLE	2521 NW 41 Street, Gainesville, FL 32606	FAX: **(352) 377-9577**

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
- ☐ On the following date ____ / ____ / _____ (MM/DD/YYYY)
- ☐ On the following event: _____
- ☐ Upon my death
- ☐ Upon my written revocation

PATIENT'S SIGNATURE _____ DATE _____

WITNESS _____