Oviedo Vision Center, PA
875 Clark Street
Oviedo, FL 32765
P (407) 366 - 7655 F (407)366 - 4129

Medical Records Release Authorization

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

Patient's name: _____

Address: _____

Date of birth: _____ Phone: _____

Social security number: _____

Reason for request:

☐ Requesting records to be faxed to continuing care physician. (No charge)

☐ Requesting produced hard copies of records. (Additional charge)

I (patient's name/guardian), _____, do hereby authorize and request Oviedo Vision Center to release the complete history records in your possession, concerning my illness and/or treatment to include any and all records.

I understand that:

1 I have the right to revoke this authorization at any time in writing and to present my written revocation to Oviedo Vision 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 an administrative fee of $20.00 and additional $1.00 per page(for first 25 pages) and $0.25 per page (exceeding 25 pages).
5 Production of my records may take between 24 to 72 hours.

Release information to: _____

Name of doctor: _____

Address: _____

Phone: _____ Fax: _____

Patient's/guardian signature: _____ Date: _____