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

Medical Records Request Authorization

This form provides your authorization to request your medical records from another physician and release the information to Oviedo Vision Center. 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: ____________________ Date of Request: ____________________

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

Release information from: ____________________

Name of doctor: ____________________

Address: ____________________

Phone: ____________________ Fax: ____________________

Patient's/guardian signature: ____________________ Date: __________

Please fax all records to 407-366-4129

or

Mail to 875 Clark St. Suite A, Oviedo, FL 32765