Atlantis Vision Center
2194 Florida A1A #109
Indian Harbour Beach, FL 32937
Telephone: 321.777.1670 Fax: 321.773.0187

Patient Name: ____________________________ Date of Birth: __________________

Previous Name: ___________________________

I, __________________________________ (patient name) request and authorize that the following be released, via fax or email, to:

Doctor/Practice: ____

Address: ____

____

Email: _______________________________ Fax:_____________________

☐ Records dated: ________________ to _______________

☐ All healthcare Information

☐ Other: (Please Specify)
____

____

____

Patient Signature: ____________________________________ Date: ___________________

☐ There is a charge for this service:____
(charge details)

☐ There is not a charge for this service.

OFFICE USE ONLY	
Patient Record #: ___________________	Date Records Sent: ________________
Privacy Official Signature: _________________________________	Date:____________