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

Patient Name: _____ Date of Birth: _____

Previous Name: _____

Please fax or email the above patient's medical records to:

Atlantis Vision Center
ATTN: Office Manager/Privacy Official
Fax: 321.773.0187
Email: toni@atlantisvisioncenter.com

Requesting Medical Records from:

Name:_____

Address: _____

City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

I, _____ request and authorize that the following be released to **Atlantis Vision Center**:

☐ Records dated: _____ to _____

☐ All healthcare Information

☐ Other: (Please Specify) _____

_____

_____

Patient Signature: _____ Date: _____

OFFICE USE ONLY
Patient Record #: _____ Date of Receipt of Records: _____

Privacy Official Signature: _____ Date:_____