REQUEST FOR MEDICAL RECORDS

Please mail or fax to: **Atlantis Vision Center**
2194 Hwy A1A #109
Indian Harbour Beach, FL 32937
Phone:321-777-1670 Fax:321-777-1671

A. PATIENT INFORMATION

Patient Name:_____DOB_____
Patient Address:_____Apt/Unit_____
City:_____State:____Zip Code:_____
Contact Phone#:_____
Email:_____

B. PERMISSION TO SHARE: I GIVE PERMISSION TO SHARE MY PROTECTED HEALTH INFORMATION (PHI)

FROM:
Atlantis Vision Center
2194 Hwy A1A Suite 109
Indian Harbour Beach, FL 32937

****copying fees may apply-please check the format below**

____ 1 Visit- Free of Charge (paper)

____ 2+ Visits- $15 Flat Rate (paper)

____ Doctor to Doctor -Free of Charge

____ Patient Portal - Free of Charge
(Please provide email address in section A above)

TO: (to whom you would like the information sent)
Name:_____
Address:_____
_____
Phone:_____
Fax_____

____ Mail

____ Fax

____ Pick up in Office

***Release will be processed once payment is received**

C: INFORMATION TO BE RELEASED (Please check all that apply and specify dates)

Medical Records from _____to_____

____ Diagnostic Testing ____ Operative Reports ____ Other (please specify)

Patient Signature_____**Date:**_____