VISUALLY SOUND
OPTOMETRY

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize the entity listed below to release confidential health information about me by releasing a copy of my medical records, or summary, or narrative of my protected health information. This release is valid for one year from date of signature. Please print clearly.

PATIENT INFORMATION:

First Name: _____ Last Name _____

DOB: ___/___/_____

NAME OF PRACTICE/DOCTOR FROM WHO RECORDS ARE REQUESTED:

Practice/Doctor's Name: _____

Address: _____

Phone: _____

Fax: _____

PLEASE RELEASE THE PROTECTED HEALTH INFORMATION TO:

Visually Sound Optometry
Samantha Vavricek, O.D.
410 Palladio Pkwy, Suite 1625
Folsom, CA 95630
Phone: 916.985.6399
Fax: 916.985.0601
Email: contact@visuallysound.com

Patient or Guardian Signature: _____ **Date:** _____

Witness Name (print): _____

Witness Signature: _____ **Date:** _____

WARNING: The medical information that may be contained in this transmission is CONFIDENTIAL AND PRIVILEGED. It is unlawful for unauthorized persons to review, copy, disclose, or disseminate confidential medical information. If the reader of this warning is not the intended recipient or the intended recipient's agent, you are hereby notified that you have received this transmission in error, please notify us immediately at the telephone number listed above, and destroy or delete this communication.