EYE CARE AND SURGERY, P.C.

■

SUGARLOAF CROSSING
AT OAK GROVE
1960 ELECTRIC ROAD
ROANOKE, VIRGINIA
24018
(540) 772-7171
(540) 774-8299 FAX
1-800-650-7313
www.eyecaresurgery.com

■

WESTLAKE CENTRE
13295 BOOKER T.
WASHINGTON HWY.
HARDY, VIRGINIA
24101
(540) 721-4433
(540) 721-1400 FAX

■

33 BRITISH WOODS DRIVE
ROANOKE, VIRGINIA
24019
(540) 992-6768
(540) 992-5780 FAX

■

110 PROFESSIONAL PARK DRIVE
SUITE 5
BLACKSBURG, VIRGINIA
24060
(540) 552-4573
(540) 552-4612 FAX

Carey W. Robinson, M.D.
William M. Thompson, M.D.
Eugene H. Eng, M.D.
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Shari L. Coolbaugh, O.D.
Kari H. Boothe, O.D.
Olivia L. Schaubach. O.D.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I do hereby consent to and authorize **Eye Care & Surgery** to release to:

____
(name of doctor)

Address: ____

____

Copies of all records, any testing, lab reports, contact lens, etc, including all

Dates of service from ____________________to ____________________

Pertaining to the health care services that were provided to:

____
(name of patient)

Address: ____

____

Date of Birth: ____________________________

This authorization is for the sole purpose of treatment of said patient and will expire one year from date signed unless otherwise stated.

I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it.

I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation, this authorization shall remain in full force and effect and shall not otherwise expire.

Patient's signature: ______________________________Date __________

Or Patient's representative: ______________________________________

Relationship to patient: ____