EYE CARE & SURGERY

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

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Shari L. Coolbaugh, O.D.
Kari H. Boothe, O.D.
Olivia L. Schaubach. O.D.

AUTHORIZATION TO OBTAIN HEALTH INFORMATION

Obtain records from: _____(Doctor)

_____(Address)

_____

_____(Phone)

Release to: **EYE CARE & SURGERY, P.C.**

Copies of all records, any testing, lab reports, 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: _____