ADVANCES IN SIGHT
608 GARRISON STREET, SUITE E
LAKEWOOD, CO. 80215
(303) 232-0200
FAX (303) 232-4044

AUTHORIZATION TO RELEASE RECORDS INFORMATION

I AUTHORIZE ADVANCES IN SIGHT TO
PROVIDE VISION HISTORY RECORDS FOR:

PATIENT'S NAME: ____
PATIENT'S DATE OF BIRTH: ______________________________________

A $25.00 FEE IS REQUIRED TO RELEASE THE REQUESTED INFORMATION.

ONCE THE $25.00 RELEASE FEE AND SIGNED RELEASE FORM HAVE BEEN RECEIVED, WE WILL COMPLETE YOUR REQUEST AND MAIL OR FAX THE PATIENT INFORMATION TO THE ADDRESS OR FAX NUMBER PROVIDED BY YOU BELOW.

MAIL TO: ____
ADDRESS (INCLUDING ZIP CODE):
____
____

FAX TO: ____
FAX #: ____

PLEASE SIGN AND DATE BELOW.

____
Print patient's name

____
Patient's Signature

____
Date