V·I·P Laser Eye Center

*"Where **V**ision **I**s **P**recious and Safety comes First!"*

Clifford L. Salinger, MD - Ramsey Elhosn, MD

# Medical Records Release

Name of Patient _____ Birthdate _____

Address _____ City, _____ State, _____ Zip _____

## Authorizes:

Name of Physician _____ Name of Health Care Facility _____

Address _____ City, State, Zip _____

Telephone # _____ Fax # _____

## Release of Records to:

Clifford L. Salinger MD
Cornea & Refractive Consultants of the Palm Beaches,
V.I.P. Laser Eye Center
11020 RCA Center Drive, Suite 2001
Palm Beach Gardens, FL 33410
P: 561-624-7878 Fax: 561-626-5848

## Information to be Released:

☐ All Clinic Records ☐ Eye Records ☐ Office Notes

☐ Photographs ☐ Visual Fields ☐ Operative Reports

**Purpose/Need for Disclosure:** Further Medical Care

I Authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Signature of Patient _____ Date _____

Authorized Signature for Patient _____ Date _____

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority is: ☐ Legal ☐ Legal Guardian ☐ Next of Kin of Deceased