



Advanced Vision Institute

Authorization for Release of Information

I here by authorize:

Practice Name: _____

Doctor's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

To furnish full details of the medical care and treatment of:

Patient Name: _____

DOB: _____

To the physicians of Advanced Vision Institute:

Glenn C. Campbell, M.D.

Reason for release of records: _____

Signed: _____ Date: _____

Witness: _____ Date: _____

Advanced Vision Institute

5215 Monticello Avenue, Williamsburg, VA 23185

Phone: (757) 229-4000 Fax: (757) 220-2798

1613 Hardy Cash Drive, Hampton, VA 23666

Phone: (757) 826-9291 Fax: (757) 220-2798