Advanced Vision Institute

Authorization for Release of Information

I here by authorize the physicians of Advanced Vision Institute:

Glenn C. Campbell, M.D.

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

Patient Name: _____

DOB: _____

To the following:

Practice Name: _____

Doctor's Name: _____

Address: _____

_____

Phone Number: _____ **Fax Number:** _____

Reason for release of records: _____

_____

Signed: _____ **Date:** _____

Witness: _____ **Date:** _____

Cost of sending records (to be paid by the patient): _____

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