



**ADVANCED VISION™**  
**INSTITUTE**

An AVP Company

**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):** \_\_\_\_\_

\_\_\_\_\_

**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**