LEVITT
EYE CARE
A Division Of Florida Pediatrics, LLC

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instruction before completing and signing the authorization form.

Patient's Name _____ **DOB**_____
LAST FIRST MI

RECORDS TO BE RELEASED FROM:

Dr._____

Phone: _____

Fax: _____

RECORDS TO BE RELEASED TO:

Dr. Levitt

Phone: 813-233-2020

Fax: 813-877-6839

TYPE OF MEDICAL INFORMATION REQUESTED:

- Complete Medical Record
- Initial Clinic Note and Last 2 Clinic Notes
- All Visual Fields, OCT'S, Etc.
- Other: _____

Please allow 2-6 weeks for medical records to be processed.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services, and treatment for alcohol and drug abuse or self-paid services. You are hereby *specifically authorized to release* all information or medical records relating to such a diagnosis, testing, or treatment, unless specifically excluded below.

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

Patient Signature_____ Date: _____