



Family Vision Care Center

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Patient's Authorization for Release of Medical Information

I, the undersigned, hereby authorize the physician and/or medical provider in receipt of this authorization to release copies of my true and complete medical records, visual fields examination, laboratory test and radiology reports related to all care and treatment provided to me. This request is made pursuant to **Public Health Law Section 18.**

A copy or facsimile of this authorization shall be accepted as an original.

Patient Name

Date of Birth

Signature of Patient/Legal Guardian

Date

___ Records will be picked up by: _____

___ Records will be mailed to: _____

___ Fax Records to: **518-580-8589**