Robert S. Webster, O.D.

Professional Eye Care

LaRue I. Collins, O.D.

In a warm and friendly atmosphere

AUTHORIZATION TO RELEASE INFORMATION

Patient's Name ______________________________ Date ________________
Patient's Date of Birth ________________

Records Requested: ____
____

I authorize: ____
____
____

to release the above requested records to:
Robert S. Webster, O.D.
La Rue I. Collins, O.D
171 S. Central Ave
Oviedo, FL 32765

This authorization will remain in effect for six months; at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by the patient at any time.

This information is CONFIDENTIAL. The disclosure of the information is strictly prohibited without the written permission of the person to whom it pertains.

The undersigned hereby releases the above mentioned institution from any liability which may arise from release and/or examination of the information indicated above. I understand that there may be a charge for copies and record review, and that such charges must be paid prior to review or release of copies.

____
(Patient's Signature)

Oviedo Eye Care

171 S Central Ave
Oviedo, FL 32765
407-365-7475
Fax (407) 365-6919
www.oviedoeyecare.com

Port St. John Eye Care

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