"We take your eyes to heart"

Lawrenceville Family Eyecare
Gwinnett Medical Building
575 Professional Drive, Suite 100
Lawrenceville, GA. 30046
T: (678) 993-2020
F: (678) 993-2000

PERMISSION TO RELEASE PATIENT'S RECORDS

Patient: _______________________________________DOB _______________Date ______________________

I grant permission to this office to release my patient records to____ ____ The medical findings and treatment disclosed should cover the period of time from _________________________ to ___________________________________. In initiating this request, I hereby release my practitioner from any laws governing the disclosure of confidential or privileged information.

Reason for request: ___ Report for primary care doctor

___ Report for specialist

___ Report for another eye doctor

___ Personal copy/moving

___ Other ____

Signature of Patient ______________________________________

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PERMISSION FOR RELEASE OF SPECTACLE/CONTACT LENS PRESCRIPTION

Patient: ___________________________________DOB_______________Date ______________________

I grant permission to provider to release my current prescription to the Lawrenceville Family Eyecare, Dr. Mehdi Kazem.

Name of Provider: ____

Attention: ____

Phone number: __________________________ Fax number: _________________________

Contact Lens Prescription: ________

Eye Glass Prescription: ________

Both: ________

I give my permission to FAX this information. I am aware that this form may contain protected health information________
Initial Please

____
Patient or Parent/Legal Guardian Signature

____
Relationship to Patient (if other than patient)