Family Vision Care Center
205 Lake Avenue, Saratoga Springs, NY 12866
518-584-6111

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