VISION SOURCE®

Drs. Thamel, Ricciardi, Cerio, Thamel & Houston

335 Park Ave Worcester, MA 01610

Phone (508) 753-5103 Fax (508) 753- 6395

Authorization for Release of Medical Records

Patient Name: _____
Date of Birth (DOB): _____
Phone Number: _____

Records Requested (check all that apply)

■ Complete Medical Record ■ Exam Notes ■ Contact Lens Information ■ Glasses Prescription ■ Diagnostic Testing / Imaging ■ Other: _____

Purpose of Disclosure

■ Continuation of Care ■ Personal Use ■ Insurance ■ Legal ■ School ■ Other ■

Recipient of Records

Name / Office: _____
Phone: _____ Fax: _____
Email (if applicable): _____

Method of Delivery

■ Fax ■ Secure Email ■ Mail ■ Patient Pick-Up

Authorization & Acknowledgment

I authorize Vision Source to release the medical records specified above. I understand this authorization is voluntary, may be revoked in writing at any time, and will expire one (1) year from the date of signature unless otherwise specified.
Expiration Date 1-year: _____

Patient Signature

Signature: _____ Date: _____

If signed by a legal representative
Representative Name: _____
Relationship to Patient: _____