Visionary Eye Doctors

Advanced technology with a loving touch

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____
to release my healthcare and request they be transferred to:

Name: Visionary Eye Doctors

Address: 11300 Rockville Pike, Suite 1202

City: Rockville State: MD Zip: 20852

Phone: (301) 896-0890 Fax: (301) 896-0968

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ Other:

_____

Patient Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED