

### **Patient Provider Release**

I allow ReFocus/Ophthalmology Physicians & Surgeons, P.C. to share my medical information with the providers listed below. I consent to the release of my visit notes and any other medical information to be sent to:

1) Medical Practice Name: \_\_\_\_\_

Medical Practice Phone Number: \_\_\_\_\_

Medical Practice Fax Number (if known): \_\_\_\_\_

Provider Name: \_\_\_\_\_

2) Medical Practice Name: \_\_\_\_\_

Medical Practice Phone Number: \_\_\_\_\_

Medical Practice Fax Number (if known): \_\_\_\_\_

Provider Name: \_\_\_\_\_

3) Medical Practice Name: \_\_\_\_\_

Medical Practice Phone Number: \_\_\_\_\_

Medical Practice Fax Number (if known): \_\_\_\_\_

Provider Name: \_\_\_\_\_

Additionally, I consent to my medical information to be released to any medical facility or provider requesting upon my behalf.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date