SKYVISION™
CENTERS

Patient Authorization for Release of Records

Date:_____
Patient Name:_____
Date of Birth:_____

Address:_____
_____
_____
Phone:_____Cell:_____

Reason for Records Release:_____
_____

Patient Signaure:_____

Please Choose an Option

☐ Please forward all of my medical records **from** SkyVision Centers to the following office.

Physician Name_____
Physician Address_____
_____
Physician Phone_____
Physician Fax_____

☐ Please have all of my records sent **to** SkyVision Centers at:

SkyVision Centers
2237 Crocker Road
Suite 100
Westlake, OH 44145
Phone: 440-892-3931
Fax: 440-892-3416

☐ I would like a copy of my medical records for my own personal documentation.

Office Use Only

☐ Approved for release of medical records
*Doctors Signature*_____

☐ Charge patient $25.00 fee for release of records

☐ No Charge for patients release of records