



*Envisions Eyecare Centers, Inc*

*Elegance N Eyewear Boutique*

**Dr. John S. Corvese and Associates**

<b>EAST PROVIDENCE</b> 1970 Pawtucket Avenue East Providence, RI 02914 (401) 438-1166 (Tel.) (401) 603-4169 (Fax)	<b>PROVIDENCE</b> 319 Pocasset Avenue Providence, RI 02909 (401) 942-1444 (Tel.) (401) 603-4170 (Fax)	<b>CRANSTON</b> 868 Reservoir Avenue Cranston, RI 02910 (401) 942-9933 (Tel.) (401) 603-4171 (Fax)	<b>WEST WARWICK</b> 328 Cowesett Avenue West Warwick, RI 02893 (401) 821-4300 (Tel.) (401) 603-4568 (Fax)	<b>NORTH PROVIDENCE</b> 1543 Smith Street North Providence, RI 02911 (401) 353-2010 (Tel.) (401) 603-4570 (Fax)
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## Medical Information Request/Release Authorization

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to disclose and release all medical information to:

- Envisions Eyecare Centers, Inc
- Other entity indicated below

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that my records are maintained in accordance with Family Education Rights and Privacy Act and the General Laws of Rhode Island and cannot be disclose without my written consent except as otherwise specifically provided by Law.

Any information released or received as result of this consent shall not be further relayed in any way to any other person, organization, entity or other without an additional written consent from me.

I may withdraw this consent by giving written notification to the above party at any time prior to disclosure of release of the information. In the absence of my prior withdrawal, this consent will expire 90 days after it is signed.

I have read this notice and consent prior to signing and understand its contents.

Patient Signature \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

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FOR HEALTH CARE USE ONLY

DATE RELEASE SENT \_\_\_\_\_ REVIEWED BY \_\_\_\_\_

DATE OF INFORMATION RECEIVED \_\_\_\_\_