

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name:	Date of Birth:	Phone Number:	_
I authorize Kismet New Vision Holdings, LLC (the	e "Company") to release	the following information from my medical record:	:
Complete Treatment Record with	out limitation		
Treatment Record of the following	g Date(s)		-
Billing and payment records			
Other (describe):			
I authorize the following person(s) or organization	on to receive the inform	nation:	
Name:			
Address:			
I prefer the records be faxed to:			
I prefer the records be emailed to:			
		by choice, in which case this authorization will expi on in reliance upon this authorization.	re on
•	ol or substance abuse, d	ecords that might contain sensitive information including related conditions, mental health conditions, detic testing and/or HIV/AIDS related conditions.	_
longer be protected by federal law. If the inform receiving this information are hereby notified th	nation released under th nat federal rules prohibit	orization could be subject to redisclosure by the rec nis consent includes alcohol or drug treatment recor t you from making any further disclosure of this info person to whom it pertains or as otherwise permitte	rds, the person(s) ormation unless
I understand that my refusal to sign this authorisbenefits.	zation will not affect my	ability to obtain treatment, payment, enrollment o	or eligibility for
	ng, in writing, the Medica	osed, as provided by federal and state law. I underst al Records Custodian (address listed below). I furthe used in response to this authorization.	-
• •	y reserves the right to s	al responsibility or liability for disclosing protected hend the record to the physical mailing address of th	
Printed name of patient		Date	
Signature			

Note: Please allow 30 days for fulfillment or transfer of your medical records request. This is a general estimate and could require more or less time depending on several factors like when you had your procedure. If your medical records are needed for an important appointment or procedure with another doctor's office, please plan with the fulfillment period in mind. To ensure we protect your patient information there is not a way to expedite the records fulfillment process. Records are only kept for 10 years before they are destroyed.

You may send your completed authorization to RecordsRequest@Lasik.com, by fax to (513) 672-9749 or by regular mail to Medical Records

Custodian, 7840 Montgomery Rd., Cincinnati, OH 45236