

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name:	Date of Birth:	Phone Number:	_
I authorize Kismet New Vision Holdings, LLC (the "C	Company") to release	the following information from my medical record:	
Complete Treatment Record without	t limitation		
Treatment Record of the following D	ate(s)		
Billing and payment records			
Other (describe):			
I authorize the following person(s) or organization	to receive the informa	ation:	
Name:			
Address:			
I prefer the records be faxed to:			
I prefer the records be emailed to:			
This authorization will expire in 90 days after the date below, or sooner by choice, in which case this authorization will expire on, except to the extent action has already been taken in reliance upon this authorization.			
I authorize the release of any information containe concerning diagnosis and/or treatment of alcohol of disabilities, sexually transmitted diseases, commun	or substance abuse, dr	rug related conditions, mental health conditions, de	•
I understand that treatment information released plonger be protected by federal law. If the information receiving this information are hereby notified that further disclosure is expressly permitted by the writed	ion released under thi federal rules prohibit	s consent includes alcohol or drug treatment recor you from making any further disclosure of this info	ds, the person(s) rmation unless
I understand that my refusal to sign this authorizat benefits.	ion will not affect my	ability to obtain treatment, payment, enrollment o	r eligibility for
I understand that I may inspect or copy information revoke this authorization at any time by notifying, the revocation will not apply to information that ha	in writing, the Medica	l Records Custodian (address listed below). I furthe	
I understand that the Company and its workforce a authorized by my signature below. The Company re medical record is too large to send/receive by ema	eserves the right to se		
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