Sharper Vision, PA
23401 Prairie Star Parkway
Suite 225
Lenexa, KS 66227
Phone 913 787 6724
FAX 913 273 1210

Aaron R. Florkowski, MD

Authorization for Release of Medical Information

Patient Information

Patient Name ________________________
Date of Birth _____________
SSN _____ ____ ________

Practice Information:

Practice Name __________________
Street Address__________________
City ___________________________
State ___ ZIP Code _________

Specific Information Requested:____

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Office Notes	___	Operative Reports	___
Visual Fields	___	Photographs	___
Nerve Fiber Analysis	___	Labs/Radiography	___
OCT	___		

I hereby authorize the release of information contained in my medical records to Sharper Vision, PA. for the purpose of continuing treatment. Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date. I may however cancel this authorization in writing at any time, except to the extent that the above named practice has relied upon it. I understand that this authorization is voluntary and that I may refuse to sign this authorization.

Signature of Patient/Guardian ___________________________________ **Date**________