Doctors

Farrell C. Tyson, MD, FACS
Board Certified Ophthalmologist
Cataract & Refractive Surgery

J. David Stephens, MD
Board Certified Ophthalmologist
Cataract, Cornea, & Glaucoma Surgery

Roman O. Pravak, MD
Board Certified Ophthalmologist
Retina Specialist

Katia E. Taba, MD
Board Certified Ophthalmologist
Retina Specialist

John Patrick, MD
Board Certified Anesthesiologist
Consulting Anesthesiologist

Janice I. Birr, OD
Chief of Optometry
Board Certified Optometrist

Stuart I. Kaplan, OD
Board Certified Optometrist

Jennifer L. Gallo, OD
Board Certified Optometrist

Rory D. Brienen, OD
Board Certified Optometrist

Offices

Main Office - Cape Coral
4120 Del Prado Blvd. S-

North Fort Myers
18770 Tamiami Trail N

East Fort Myers
11571 Verandah Blvd

South Fort Myers
8004 Vintage Parkway

Bonita Springs
3925 Bonita Beach Road

Naples
2640 Golden Gate Pkwy, #115

Surgery Centers

Eye Surgery and Laser Center Cape Coral
4120 Del Prado Blvd. S-

Naples Premier Surgery Center
2335 Tamiami Trail N. #304

Practice Administrator

Mark King, COE

TYSON EYE

239•542•2020 | TysonEye.com

Request for Records

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT			
DATE OF BIRTH		SS#	

TO: (Name, Address, Phone of **Recipient** of Records)							
Name	Tyson Eye				Phone	(239) 542-2020	
Address	4120 Del Prado Blvd				Fax	(239) 541-1492	
	City	Cape Coral	State	FL		Zip	33904

RECORDS FROM: (Who is **Releasing** the Records)						
Name				Phone		
Address				Fax		
	City		State		Zip	

For the Following Purposes:

☐	Continued Medical Care	☐	Personal Information	☐	Legal Follow-up
☐	Disability Insurance	☐	Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

☐	Please send the entire Medical Record (all information) to the above named recipient.				
☐	Office Notes and Reports	☐	Diagnostic Reports	☐	Billing Statements
☐	Rx History	☐	Transcribed Hospital Reports	☐	Laboratory Reports
☐	Others Listed Here:				

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases
_____ Mental Health Information and/or Records
_____ Domestic Violence
_____ Genetic Testing Information and/or records
_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require description of how much and what kind of information is to be disclosed.)
Describe: _____
_____ Other: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

I give authorization to the provider listed above to disclose a copy of the specific health/medical information identified above:

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____