VISION SOURCE™
4114 Marigny Street
New Orleans, LA 70122
504-288-2333 O
504-288-2227 F

Release Of Records

Patient Name: _____

Patient Date of Birth: _____

Patient Guardian: _____
(if applicable)

Patient Address: _____

I authorize **Gentilly Vision Source** to release medical records through an unsecure email. I understand this violates HIPAA regulations and there are risks involved. I give my consent through this signed and dated letter and will provide a photo ID with my name and picture as proof of identity.

Please send the records to the following email address:

_____

Attention: _____

Thank you,

_____

Patient/Guardian Signature Today's Date