



**Envisions Eyecare Centers, Inc**

**Elegance N' Eyewear Boutique**

**Dr. John S. Corvese and Associates**  
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**EAST PROVIDENCE**  
1970 Pawtucket Avenue  
East Providence, RI 02914  
(401) 438-1166 (Tel.)  
(401) 438-1614 (Fax)

**PROVIDENCE**  
319 Pocasset Avenue  
Providence, RI 02909  
(401) 942-1444 (Tel.)  
(401) 223-7149 (Fax)

**CRANSTON**  
868 Reservoir Avenue  
Cranston, RI 02910  
(401) 942-9933 (Tel.)  
(401) 270-2491 (Fax)

**WEST WARWICK**  
328 Cowesett Avenue  
West Warwick, RI 02893  
(401) 821-4300 (Tel.)  
(401) 381-0084 (Fax)

**NORTH PROVIDENCE**  
1543 Smith Street  
North Providence, RI 02911  
(401) 353-2010 (Tel.)  
(401) 353-0380 (Fax)

## Medical Information Request/Release Authorization

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_

DOB: \_\_\_\_\_  
Home # \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to disclose and release all medical information to:

- Envisions Eyecare Centers, Inc
- Other entity indicated below

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that my records are maintained in accordance with Family Education Rights and Privacy Act and the General Laws of Rhode Island and cannot be disclosed without my written consent except as otherwise specifically provided by Law.

Any information released or received as result of this consent shall not be further relayed in any way to any other person, organization, entity or other without an additional written consent from me.

I may withdraw this consent by giving written notification to the above party at any time prior to disclosure of release of the information. In the absence of my prior withdrawal, this consent will expire 90 days after it is signed.

I have read this notice and consent prior to signing and understand its contents.

Patient Signature \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

FOR HEALTH CARE USE ONLY

DATE RELEASE SENT \_\_\_\_\_ REVIEWED BY \_\_\_\_\_

DATE OF INFORMATION RECEIVED \_\_\_\_\_