Records Release

Date:_____

To: _____
Doctor/Physician

Address: _____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

I authorize the release of my records and request that they be transferred to:

Performance Vision
Dr. Kenneth R. Winton
6511 Highway 431, Suite A
Owens Cross Roads, AL 35763
E-Mail: Office@pvhsv.com
Phone #: 256– 469-6427
Fax #: 256-888-1299

_____

Print name of patient Date of Birth

_____

Signature (patient, parent, guardian)