Gulani Vision
INSTITUTE
...Vision for the World

We appreciate your interest in seeking us for your vision corrective surgery and request you or your eye surgeon/doctor to fill these basic details regarding your eyes so we can review prior to your personal teleconference with Dr. Gulani.

Patient Name: **Date of Birth:**

Your Eye Doctor's Name: **Phone:** **Email:**

VA (Vision): (OD): Sc:
Cc:
(OS): Sc:
Cc:

Manifest Refraction:
(OD): , x :20/
(OS): , x :20/

Glasses Prescription:
(OD): , x :20/
(OS): , x :20/

Contact Lens Prescription (Type of contact lenses: Soft/RGP/Scleral)**:**
(OD): , x :20/
(OS): , x :20/

Eye Exam Note to Include:
Status of your Cornea and Natural Lens:
Status of your Retina (if any retinal problems):
Stability of Glaucoma (if history of glaucoma):
History of eye surgeries with dates and surgeon names if possible:
Basic Tests: Corneal Topography/ Slit Lamp Image-photo / Cl Trial (in corneal scar cases):

We at Gulani Vision Institute will conduct our own advanced diagnostics given the level of Dr. Gulani's assessment in his personal consultation but the above information will allow us to prepare for you accordingly before you travel to us.

Tele: 904-296-7393 Fax: 888-397-4699 Email: gulanivision@gulani.com

To ensure you are sending us the correct data regarding your eye exam, please sign this form and send it to your eye doctor so they can email us your reports directly.

Gulani Vision Institute

Authorization for Release of Medical Information

Patient Name: ____ SSN: ______-_________-________

Date of Birth: ____/_____/______ Phone: (_____) _____-__________ Email: ______________________________

I Authorize Release of Medical Records to: Gulani Vision Institute

Please email and fax records to: visionservices@gulani.com and (888)-397-4699

Please check the following and include name, addresses and telephone numbers:

To obtain from: ____

____

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To release to:

GULANI VISION INSTITUTE
8075 Gate Parkway West Ste. 102
Jacksonville, Florida 32216
Phone: (904) 296 – 7393
Fax: (888) 397 – 4699

The information is needed for the following purposes:

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I understand that these records are of a privileged and confidential status. I waive the status for the purpose contained within this authorization. I agree to hold GVI (Gulani Vision Institute) harmless from any and all cost, liability and damages of any nature whatsoever, including attorney fees, resulting directly or indirectly from GVI release of these records pursuant to this consent. This authorization will automatically expire one (1) year following date of signature without my express revocation.

I acknowledge that I have read and understand this authorization and its content:

____ ____/_____/_____ ______________________

Signature of Patient/Legal Guardian Date Relation to patient

Prohibition of Disclosure: The information is being disclosed to you from records whose confidentiality is protected by state laws, specifically FL Statutes 395.325, 455.667, & 394.459. State laws prohibit you from any further disclosure of this date without the specific written consent of the person to whom it pertains, or as otherwise permitted by Florida state statutes and regulations. A General Authorization is not sufficient for this purpose.