Medical Release Form

Patient Name _____ Date of Birth ____/____/____

SSN _____ Address _____ City _____

State _____ Zip Code _____ Phone ( ) _____ Email _____

INFORMATION REQUESTED FROM

Name _____

Address _____ City _____ State _____ Zip Code _____

Phone ( ) _____ Fax ( ) _____ Email _____

SEND INFORMATION TO

Name Eye Care Associates of Sarasota Send by ☐ Mail ☐ Fax ☐ Secure Email

Address 1219 S East Ave #105 City Sarasota State FL Zip Code 34239

Phone (941) 957-4216 Fax (941) 954-1835 Email cburr@srqeyecare.com

Specific Items needed: First exam, last exam, any operative notes and visual field tests

Other: _____

I, _____(*Name*), herby grant permission for you to release confidential health inormation about me, by releasing a copy of my medical record, or a summay or narrative of my protected health information, to the physician / person/ facility/ entity

_____ _____

Printed Name Date

_____ _____

Signature Date