GULFCOAST EYE CARE

## Authorization to Release Medical Information

**Patient Information:**

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

**Request Medical Information from:**

❑ Gulfcoast Eye Care

❑ Other

Physician / Practice Name: _____

Address: _____Phone:_____

City: _____ State: _____ Zip Code: _____ Fax: _____

**Send Medical Information to:**

❑ Gulfcoast Eye Care

❑ **Palm Harbor**: 2650 Tampa Road, Ste A ● Palm Harbor, FL 34684 ● 727.785.4419 ● Fax 727.789.3351

❑ **Pinellas Park**: 6036 Park Boulevard ● Pinellas Park, FL 33781 ● 727.549.2105 ● Fax 727.768.0488

❑ Other

Physician / Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

❑ The complete medical records in your possession, concerning my illness and/or treatment during the period from _____ to _____

❑ Other: _____

**Reason(s) for Records Request:**

❑ Moving out of the area

❑ Insurance change. If so, new insurance: _____

❑ Change of provider. If so, name: _____

❑ Primary physician needs records

❑ Copy for northern physician

❑ Other (please explain): _____

_____ _____

Patient or Legal Representative Date Witness Date

At Gulfcoast Eye Care, we consider it a privilege to be entrusted with your care.

Please allow 10 days for processing your request.

**www.gulfcoasteyecare.com**