AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT INFORMATION

Name: ______________________ Date of Birth: ______________

Address: ____

City: ______________ State: _______ Zip: _______ Phone: ______________

REQUEST MEDICAL INFORMATION FROM:

❍ Gulfcoast Eye Care ❍ Other

Physician/Practice Name: ______________________________

Address: ______________________ Phone: ______________

City: ______________ State: _______ Zip: _______ Fax: ______________

SEND MEDICAL INFORMATION TO:

❍ Gulfcoast Eye Care

❍ **Palm Harbor**: 2650 Tampa Road, Suite 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

❍ **St. Petersburg**: 1515 9th Avenue North | St. Petersburg, FL 33705 | (727) 895-2020 | Fax (727) 823-8796

❍ Other

Physician/Practice Name: ______________________________

Address: ______________________ Phone: ______________

City: ______________ State: _______ Zip: _______ Fax: ______________

❍ The complete medical records in my possession, concerning my illness and/or treatment during the period from ______________ to ______________ by ❍ Email: ______________ ❍ Fax: ______________

❍ Mail:

Address: ______________________ Phone: ______________

City: ______________ State: _______ Zip: _______ Fax: ______________

REASON(S) FOR RECORDS REQUEST:

❍ Moving out of the area ❍ Insurance change. If so, name: ______________

❍ Change of provider. If so, name: ______________________________

❍ Primary physician needs records ❍ Copy for northern physician ❍ Second opinion

❍ Other (please explain): ______________________________

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Patient/Legal Guardian Signature **Date** **Witnessed By**

At Gulfcoast Eye Care, we consider it a privilege to be entrusted with your care.
Please allow 10 days for processing your request.