



MEDICAL INFORMATION RELEASE FORM

Patient Information:

Name:		
Address:		
City:	State:	Zip:
Phone:	Date of Birth:	

Request Medical Information FROM:

Center For Sight Other (fill in information below)

Physician/Practice Name:			
Address:			
City:	State:	Zip:	Phone:

Send Medical Information TO:

Center For Sight

- AMARA:** 1370 East Venice Avenue, Suite# 205 – Venice, FL 34285 – 941.263.4799 Fax 941.412.0074
- Sarasota:** 2601 South Tamiami Trail – Sarasota, FL 34239 – 941.925.2020 Fax 941.330.2200
- Venice:** 1360 East Venice Avenue – Venice, FL 34285 – 941.488.2020 Fax 941.488.2503
- Englewood:** 1800 S. McCall Road – Englewood, FL 34223 – 941.474.2020 Fax 941.473.4142
- North Port:** 14844 Tamiami Trail – North Port, FL 34287 – 941.484.2020 Fax 941.426.8701
- Siesta Drive:** 1800 Siesta Drive – Sarasota, FL 34239 – 941.953.2020 Fax 941.953.2046
- University Park:** 5409 University Parkway – University Park, FL 34201 – 941.330.2020 Fax 941.351.9446
- Pelican Plaza:** 8224 South Tamiami Trail – Sarasota, FL 34238 – 941.918.2020 Fax 941.918.2036
- Jacaranda:** 1236 Jacaranda Boulevard – Venice, FL 34292- 941.496.4444 Fax 941.496.4223
- Naples:** 700 Neapolitan Way – Naples, FL 34103 – 239.261.8383 Fax 239.261.8443
- Sarasota -Soto:** 2650 S. Tamiami Trail – Sarasota, FL 34239 – 941.953.3111 Fax 941.366.5670

Other:

Name:		
Address:		
City:	State:	Zip:

Complete medical records in your possession, concerning my illness and/or treatment during the period from _____ to _____.

Reason(s) for Records Request:

- Moving out of the area
- Insurance Change. New Insurance: _____
- Change of provider. Provider Name: _____
- Primary physician needs records
- Copy for northern physician
- Other (please explain): _____

I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This Release of Information will remain in effect until terminated by me in writing.

Patient or Legal Representative

Date

Witness

Date

At Center For Sight, we consider it a privilege to be entrusted with your care. Please allow 10 business days for processing your request.

FOR OFFICE USE ONLY					
Release Approval	Dr. Shoemaker	Dr. Kim	Dr. Soccia	Dr. McCann	Dr. De Rojas
Date:	Dr. Lahners	Dr. Fezza	Dr. Banker	Dr. Newman	Dr. Berlie
Dr. Carter	Dr. Brinnig	Dr.	Dr.	Dr.	Dr.
Catherine F	Request Completed (2 sets of staff initials) _____				