CENTER FOR SIGHT

Authorization to Release Medical Information

Patient Information:

Name: ____ Date of Birth: __________________

Address: ____

City: ___________________ State: _____ Zip Code: ____________ Phone: _______________________

Request Medical Information from:

❑ Center For Sight

❑ Other

Physician / Practice Name: ____

Address: ____

City: ___________________ State: _____ Zip Code: _________ Phone: ___________________

Send Medical Information to:

❑ Center For Sight

- ❑ **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
- ❑ **Bradenton:** 5219 East State Road 64 – Bradenton, FL 34208 – 941.756.3937 Fax 941.748.8498
- ❑ **Englewood:** 406 Indiana Avenue North – 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:** 8433 Tuttle Avenue – Sarasota, FL 34243 – 941.351.9440 Fax 941.351.9446

❑ Other

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 Center For Sight, we consider it a privilege to be entrusted with your care.

Please allow 10 days for processing your request.

www.centerforsight.net

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