
1601 Sawgrass Corporate Parkway
Suite #430
Sunrise, FL 33323
Phone: 954-653-0100
Fax: 954-607-5977

# RECORD RELEASE

Date: _____

From: Dr. Andrew C. Shatz
SightTrust Eye Institute
1601 Sawgrass Corporate Parkway
Suite 430
Sunrise, FL 33323

I hereby authorize and request you to release

To: _____
_____
_____
_____

The complete Medical Records in your possession concerning my illness and/or

treatment during the period from _____to _____

Printed Name:_____

Patient Signature: _____

Patient Date of Birth:_____

Witness Signature: _____

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OFFICE USE ONLY

Records reviewed / released by: _____ Date: _____
Physician Signature

Sent by: _____ Date: _____Via: Fax / Mail
Staff Signature Circle One