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

RECORD RELEASE

Date: _____

From: _____
Doctor

_____
Address

_____
Fax

I hereby authorize and request you to release

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

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: _____

Please fax all records to 954-607-5977. Thank you for your assistance in this matter.