



SIGHT TRUST

EYE INSTITUTE

1000 Sawgrass Corporate Parkway

Suite #500B

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
1000 Sawgrass Corporate Parkway
Suite 500B
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.