# AUTHORIZATION FOR RELEASE OF INFORMATION
# REQUEST FOR MEDICAL RECORDS TO:


**Fort Lauderdale Eye Institute**
850 S. Pine Island Rd., Suite A100 • Plantation, FL 33324
Phone: 954-741-5555 • Fax: 954-741-6298

**Fort Lauderdale Retina Institute**
1930 N.E. 47th St., Suite 101, Ft. Lauderdale, FL 33308
Phone: 954-772-3337 • Fax: 954-772-2033


Keith Skolnick, M.D.
Ilan Epstein, M.D.
Luis Fernandez de Castro, M.D.
Stuart Burgess, M.D.
Tirso Lara, M.D.
Natalia Villate, M.D.
Gil Epstein, M.D.
Aliza Epstein, M.D.
Lisa Galluzzo, O.D.

Other Provider: _____

Date of Request: _____

Name of Patient: _____ Date of Birth: _____/_____/_____

I hereby give my permission to: _____

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To release a copy of my medical records [ ] All [ ] Specific date and services – listed below

_____

_____

Purpose of disclosure _____

Authorization expires in 1 year or date indicated _____

To: [ ] Fort Lauderdale Eye Institute [ ] Fort Lauderdale Retina Institute

Address: 850 S. Pine Island Road, Suite A100 1930 N.E. 47th Street, #101

Plantation, FL 33324 Fort Lauderdale, FL 33308

For the purpose of Alcohol & HIV patient (only):

This is a [ ] single disclosure or [ ] a continuing disclosure for 1 year
(check one)

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I hereby release the facility from any liability which may arise as a result of the use of the information contained in the records released.

Signature of Patient_____ Date _____

Name of Guardian/Witness_____ Date _____

**RECEIVE**