AUTHORIZATION FOR RELEASE OF
MEDICAL RECORDS TO BE SENT FROM:

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:

[ ] 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

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 _____/_____/_____

Send TO: _____

Address: _____

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

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

_____

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 _____

SEND