Gainesville Eye Physicians
TOTAL EYE CARE
LASER CATARACT SURGERY • FACIAL PLASTIC SURGERY

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MEDICAL RECORDS RELEASE FORM

◯ I authorize Gainesville Eye Physicians to **OBTAIN** my medical records from:

_____
Dr Name /Facility

_____
Mailing Address

_____
City ST Zip

_____
Phone

_____
Fax

◯ I authorize Gainesville Eye Physicians to **RELEASE** my medical records to:

_____
Dr Name /Facility

_____
Mailing Address

_____
City ST Zip

_____
Phone

_____
Fax

Information to be disclosed or released: (circle all that apply)

Office notes Visual Field OCT Entire Chart Other:_____

******There is a cost for a copy of your records ($1.00 per page up to 25 pages and $.25 for every page above 25 pages)******

_____ _____
Patient Legal Name (Print) **Date of Birth**

_____ _____
Patient Signature **Today Date**