FLORIDA EYE
Microsurgical Institute, Inc.
Phone: 561-737-5500 Fax: 561-737-7055

MEDICAL RECORDS RELEASE

Patient Information:

Full Name:	Phone:
Address Line 1:	DOB:
Address Line 2:	SSN #:
City and State:	Zip:

Request Records from:	**Send Records to:**
Doctor/Clinic Name:	Doctor/Clinic Name:
Address Line 1:	Address Line 1:
Address Line 2:	Address Line 2:
City, State Zip:	City, State Zip:
Phone:	Phone:
Fax #:	Fax #:

Requesting Office notes: from_____ to_____ **Other:** _____
(date) (date) (example: labs, mri)

Signature _____ **Date** _____
(Patient or Legal Guardian)

Witness _____ **Date** _____
(Staff Member)

The Records can be: **Mailed** to: 1717 Woolbright Road
Boynton Beach, Fl. 33426

Faxed to: 561-737-7055

Emailed to: **loralee@fleyedocs.com**