



# 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** \_\_\_\_\_  
 (Patient or Legal Guardian)

**Date** \_\_\_\_\_

**Witness** \_\_\_\_\_  
 (Staff Member)

**Date** \_\_\_\_\_

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

**Faxed** to: 561-737-7055

**Emailed** to: [loralee@fleyedocs.com](mailto:loralee@fleyedocs.com)