SOUTHWEST FLORIDA EYE CARE

Records Release Authorization

I hereby authorize and request you to release my complete medical record in your possession concerning my illness and/or treatment during the period from _____ to _____.

TO BE RELEASED FROM:

_____

_____

_____

_____

SENT TO:

□ 6850 International Center Blvd
Fort Myers, FL 33912
Phone: 239-768-0006
Fax: 239-768-0850

□ 2221 Santa Barbara Blvd
Suite 107
Cape Coral, FL 33991
Phone: 239-574-5406
Fax: 239-574-9212

□ 11176 Tamiami Trail N
Naples, FL 34110
Phone: 239-594-0124
Fax: 239-594-1040

☐ F. Rick Palmon, MD ☐ Albert E Smolyar, MD ☐ Brian Marhue, OD
☐ Leonard Avril, OD ☐ Penny Orr, OD

PATIENT NAME: _____

ADDRESS: _____

_____

DATE OF BIRTH: _____

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____