Retina Care Specialists

MEDICAL RECORDS RELEASE

Patient Information:

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

Records Request 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:**

I hereby request a copy of my medical record as detailed below:

[ ] Full Medical record of this office

[ ] Medical record for the period of _____ through _____

[ ] Urgent

Records can be:

Mailed to: 3399 PGA Blvd, Suite 350 Palm Beach Gardens, FL 33410

Faxed to: Main Office: 561-624-7373 or **Surgical Coordinator**: 561-296-2417

E-Mailed to : medicalrecords@retinacarespecialists.com

If you have any questions, please call us at 561-624-0099

Signature:_____ **Date:**_____

Witness:_____ **Date:**_____