Coastal
Eye Associates

Date:_____

This authorizes _____
(Name of Physician or Hospital)

_____
Address Phone

_____
City State Zip Code Fax

To release any and all information regarding my medical condition including all dates of service to

Dr. _____ at Coastal Eye Associates.

Patient Name:_____

Date of Birth:_____SS#_____

Address:_____

City:_____State:_____Zip Code:_____

Phone No:_____

Patient
Signature:_____Date:_____

Please allow 10-14 business days for this request.

Coastal Eye Associates
Phone: 281-488-7213
Fax: 281-282-5137
medicalrecords@coastaleyeassociates.com
www.coastaleyeassociates.com