Date:____________________

This authorizes Coastal Eye Associates to release any and all information regarding my medical condition including all dates of service to:

____

(Name of Physician or Hospital)

____

Address Phone

____

City State Zip Code Fax

____

Signature of Patient or Parent for Minor

Patient Name:____DOB:__________________________

Address:____City:_________________________

State:_________Zip Code_________________Phone ____

Please circle one

Reason for request: Continuity of Care Treatment At the request of the patient

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