THE GULF COAST GLAUCOMA CLINIC
A REGIONAL GLAUCOMA REFERRAL CENTER

Ending Preventable Blindness from Glaucoma
RESEARCH MISSION: A Cure for Glaucoma

Lawrence M. Hurvitz, M.D.
Stephen M. Wahl, M.D.

RELEASE OF RECORD INFORMATION

FAX TRANSMISSION

TO:_____ FAX:_____

_____

_____

I,_____D.O.B._____wish to have copies of my records released to The GULF COAST GLAUCOMA CLINIC, 3920 Bee Ridge Rd., Bldg. F, Suite B, Sarasota, FL 34233, as provided under applicable federal law, Protective Health Information, as defined in 42 C.F.R., S160, et al.

Please include copies of all office visits, operative notes, letters to and from consultants, all visual fields, and copies of any photographs.

This may include information relating to the following, unless expressly excluded by checking the box(es):

[ ] AIDS or HIV
[ ] Genetic testing
[ ] Psychiatric care
[ ] Sexually transmitted disease (STD)
[ ] Treatment for alcohol/drug abuse

This authorization may be revoked in writing at any time, and otherwise will expire in 180 days. A photocopy or fax of this document is valid as the original.

I understand there may be a charge for copying my records as provided under federal and state law.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Date:_____

Signature of Patient or Legal Representative:

_____

Witness:_____

Our Fax #: 941-924-4751