EYE CENTERS OF SOUTH FLORIDA

"Excellence in Collaborative Eye Care since 1986"

MEDICAL RECORDS RELEASE TO PATIENT or DOCTOR

Date: _____

Patient:_____ D.O.B.: _____
Last Name First Name MI

Address:_____

City: _____State: _____ Zip Code: _____

Email: _____ Fax_____

I authorize and request the release of my complete medical records, including all information related to my illness, surgical procedures, and/or treatment received at your office.

☐ Eye Center of North Miami Beach:
1701 NE 164th Street, Suite #200
North Miami Beach, FL 33162

☐ Eye Center of Fort Lauderdale:
5333 N Dixie Highway, Suite #101
Fort Lauderdale, FL 33334

Thank you for your recent request for a copy of Medical Records. Florida Statute 456.057(6) and Florida Administrative Code Rule 64B8-10-10.003 permits the following charges for costs of reproducing paper medical records for patients and their legal representatives (attorneys): **"$1.00 per page** for the first 25 pages and **$0.25 per page** in excess of 25 & Mailing fee– may charge sales tax and actual postage".

Note: **Records are provided free of charge to physicians for continuing medical care**. According to HIPAA federal regulations, healthcare providers have up to 30 days to respond to a request for medical records.

Please send my records via: ☐ Mail ☐ Email ☐ Fax (records will be sent after payment received) or

Please fax my records to Dr. _____ (no charge)

Address_____Phone_____Fax_____

Signature of Patient: _____Date: _____
(or Authorized Person)

FOR OFFICE USE ONLY:

Past Due Balance: _____ Records Fee: _____ Total Due: _____ Paid: _____

☐ Mailed ☐ Emailed ☐ Faxed by _____ Date_____

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