CENTER FOR SIGHT | AMARA
AESTHETIC SURGERY AND DERMATOLOGY

MEDICAL INFORMATION RELEASE FORM

Patient Information:

Name:		
Address:		
City:	State:	Zip:
Phone:	Date of Birth:	

Request Medical Information FROM: ☐ Center For Sight ☐ Other (fill in information below)

Physician/Practice Name:			
Address:			
City:	State:	Zip:	Phone:

Send Medical Information TO:

☐ **Center For Sight**

- ☐ **AMARA:** 1370 East Venice Avenue, Suite# 205 – Venice, FL 34285 – 941.263.4799 Fax 941.412.0074
- ☐ **Sarasota:** 2601 South Tamiami Trail – Sarasota, FL 34239 – 941.925.2020 Fax 941.330.2200
- ☐ **Venice:** 1360 East Venice Avenue – Venice, FL 34285 – 941.488.2020 Fax 941.488.2503
- ☐ **Englewood:** 1800 S. McCall Road – Englewood, FL 34223 – 941.474.2020 Fax 941.473.4142
- ☐ **North Port:** 14844 Tamiami Trail – North Port, FL 34287 – 941.484.2020 Fax 941.426.8701
- ☐ **Siesta Drive:** 1800 Siesta Drive – Sarasota, FL 34239 – 941.953.2020 Fax 941.953.2046
- ☐ **University Park:** 5409 University Parkway – University Park, FL 34201 – 941.330.2020 Fax 941.351.9446
- ☐ **Pelican Plaza:** 8224 South Tamiami Trail – Sarasota, FL 34238 – 941.918.2020 Fax 941.918.2036
- ☐ **Jacaranda:** 1236 Jacaranda Boulevard – Venice, FL 34292- 941.496.4444 Fax 941.496.4223
- ☐ **Naples:** 700 Neapolitan Way – Naples, FL 34103 – 239.261.8383 Fax 239.261.8443
- ☐ **Sarasota -Soto:** 2650 S. Tamiami Trail – Sarasota, FL 34239 – 941.953.3111 Fax 941.366.5670

☐ **Other:**

Name:		
Address:		
City:	State:	Zip:

☐ Complete medical records in your possession, concerning my illness and/or treatment during the period from _____ to_____.

Reason(s) for Records Request:

- ☐ Moving out of the area
- ☐ Insurance Change. New Insurance: _____
- ☐ Change of provider. Provider Name: _____
- ☐ Primary physician needs records
- ☐ Copy for northern physician
- ☐ Other (please explain): _____

I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This Release of Information will remain in effect until terminated by me in writing.

_____ _____ _____

Patient or Legal Representative **Date** **Witness** **Date**

At Center For Sight, we consider it a privilege to be entrusted with your care. Please allow 10 business days for processing your request.

FOR OFFICE USE ONLY					
Release Approval	**Dr. Shoemaker**	**Dr. Kim**	**Dr. Soscia**	**Dr. McCann**	**Dr. De Rojas**
Date:	**Dr. Lahners**	**Dr. Fezza**	**Dr. Banker**	**Dr. Newman**	**Dr. Berlie**
Dr. Carter	**Dr. Brinnig**	**Dr.**	**Dr.**	**Dr.**	**Dr.**
Catherine F			**Request Completed (2 sets of staff initials)** _____		_____