27348 Cashford Circle
Wesley Chapel, FL 33544
Phone: (813) 994-7000
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MD@newtampaeyes.com

NEW TAMPA EYE INSTITUTE

Gretta Fridman, M.D.
Laurie B. Small, M.D.

Patient Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **NEW TAMPA EYE INSTITUTE** to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, specific tests or dates:

  _____

  _____

- ☐ All healthcare information

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.