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NEW TAMPA EYE INSTITUTE

Gretta Fridman, M.D.
Laurie Small, M.D.
Lorraine Simonds, M.D.
Scott Friedman, M.D
David Richards, M.D.

Patient Name:_____ Date of Birth_____

Previous Name:_____ Social Security #:_____

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

Name_____

Address_____

City_____State_____Zip_____

This request and authorization applies to:

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

_____

_____

__ All Healthcare information

Patient/Responsible Party Signature_____

Date Signed_____ This authorization expires 90 days after it is signed.

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