DELRAY EYE ASSOCIATES, P.A.

Medical Records Release Form

I authorize Drs. Steven I. Rosenfeld, Jan W. Kronish, Michael A. Schaffer, Daniel A. Jewelewicz, Marc Winnick, Ronald J. Glatzer, Mark A. Werner, Marco A. Gonzalez and/or Hadley N. Saitowitz of the Delray Eye Associates, P.A. to release a copy of my medical records to:

_____

_____

_____

I hereby request a copy of my medical record as detailed below:

[ ] Full Medical record of this office

[ ] Medical record for the period of _____ through _____

[ ] Other: _____

I understand that, unless otherwise provided by law, the charge for this record will be $1.00 for each page up to 25 pages, then $.25 per page thereafter. Color reproductions require an additional charge depending on cost.

Patient Name: _____ D.O.B: _____ Acct#: _____

Patient Signature: _____ Date: _____

Witness Name: _____

Witness' Signature: _____ Date: _____

Relationship to Patient: _____

CREDIT CARD AUTHORIZATION

I authorize DELRAY EYE ASSOCIATES, P.A. to charge my credit card for these medical records.
CHECK ONE: [ ] MasterCard [ ] Visa [ ] American Express

_____ _____ _____
Credit Card Number Security Code Expiration Date

_____ _____
Signature of Cardholder Date

16201 South Military Trail, Delray Beach, Florida 33484
(561) 498-8100 * (561) 734-0267 * FAX: (561) 498-8188