**DELRAY EYE ASSOCIATES, P.A.**

**Release Form to obtain a copy of Medical Records**

**TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please send a copy of my medical records to:**

**Steven I. Rosenfeld, M.D.**

**Jan W. Kronish, M.D.**

**Michael A. Schaffer, M.D.**

**Daniel A. Jewelewicz, M.D.**

**Marc Winnick, M.D.**

**Maria Garcia, M.D.**

**Mark A. Werner, M.D.**

**Marco A. Gonzalez, M.D.**

**Hadley N. Saitowitz, O.D.**

**Please be sure to include:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thank you for assistance.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Witness**

16201 South Military Trail, Delray Beach, Florida 33484

(561) 498-8100 \* (561) 734-0267 **\***  FAX: (561) 498-8188

Obtain Medical Record Release Form – revised 1-2021