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NEW TAMPA EYE INSTITUTE

Gretta Fridman, M.D.
Laurie B. Small, M.D.
Scott M. Friedman, M.D.
David W. 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: _____

Phone: _____ Fax: _____

This request and authorization applies to:

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

_____

_____

__ All Healthcare information

Patient/Responsible Party Name: _____

Patient/Responsible Party Signature: _____

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