The Eye Center

Medical & Surgical Eye Care

Laura Muller M.D. (727)216-2020

Authorization for Release of Medical Records

Name: (Last)_____ (First)_____ (M)_____

Last 4-digits of SSN:_____ Birth Date:_____/_____/_____

Address:_____

City:_____ State:_____ Zip:_____

I HEREBY AUTHORIZE Laura Muller, M.D.

☐ To **obtain** medical records from:

Facility/Physician
Name:_____

Phone #: (_____)_____ - _____

Fax #: (_____)_____ - _____

☐ To **release** records to:

Name:_____

Address:_____

City/State/Zip:_____

Phone #: (_____)_____ - _____

Fax #: (_____)_____ - _____

Please send my records to:
The Eye Center
Laura T. Muller, M.D.
3155 Curlew Rd.
Oldsmar, FL 34677
Fax (727)216-1173

Please release a copy of all of my medical records, including but not limited to progress notes, operative notes, laboratory results and diagnostic tests.

By my signature I authorize release of my medical records. This authorization may be revoked at any time with a written request unless the requested information has already been disclosed. This form is valid for 1 year from the date of signing.

Patient signature:_____ Date:_____

Witness: :_____ Date:_____