COASTAL EYE INSTITUTE
Formerly Manatee Sarasota Eye Clinic

Board-Certified Ophthalmologists
Fellowship-Trained Specialists

Murray L. Friedberg, M.D.
Laser Cataract Surgeon
& Cornea Specialist

Robert E. Edelman, M.D.
Laser Cataract Surgeon
& Glaucoma Specialist

Scott E. Silverman, M.D.
Pediatric Ophthalmologist
& Strabismus Surgeon

Eric L. Berman, M.D.
Neuro-Ophthalmologist
& Oculoplastic Surgeon

Robert P. Sambursky, M.D.
Laser Cataract Surgeon, LASIK
& Cornea Specialist

Pooja Khator, M.D.
Laser Cataract Surgeon
& Glaucoma Specialist

Allison V. Menezes, M.D.
Retina Specialist, Diabetes
Macular Degeneration

Jeffrey M. Davis, M.D.
Laser Cataract Surgeon
& Cornea Specialist

Anita R. Shane, M.D.
Retina Specialist, Diabetes
Macular Degeneration

Benjamin S. Davis
Administrator

Sarasota/Bradenton
(941) 748-1818

Bradenton
217 Manatee Avenue East

Lakewood Ranch
6310 Health Park Way, #340

Sarasota
1427 South Tamiami Trail

East Sarasota
2020 Cattlemen Road, #500

Sun City Center
(813) 633-3065

Sun City Center
1515 Sun City Center Plaza

Mailing Address
217 Manatee Avenue East
Bradenton, FL 34208

Fax 941-746-1055
CoastalEye.com
Mail@CoastalEye.com

MEC 5001

Consent to Release Medical Information

Patient Name:___________________________ Chart #:____________

Date of Birth:______________ Social Security #:_________________

I hereby request that my medical information be released from:

Name of Physician: ____

Address: ____

Phone #:_____________________ Fax #:_____________________

Release to:

Name of Physician:____

Address: ____

Phone #:____________________ Fax #:______________________

I understand that my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral and mental services and treatment for alcohol and drug abuse.

Yes, I consent to the release of this information

No, I do not consent to the release of this information

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to the information already released in response to this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to ensure treatment.

______________________________________ ________________

Signature of Patient or Legal Representative Date

____

Relationship to Patient (if Legal Representative)

______________________________________ ________________

Witness Date

CEI 3194