



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

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

Jody G. Abrams, M.D.
Neuro-Ophthalmologist
& Oculoplastic Surgeon

Paul A. Brannan, M.D.
Oculoplastic Surgeon

Garry P. Condon, M.D.
Laser Cataract Surgeon
& Glaucoma Specialist

Benjamin S. Davis
Administrator

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Mail@CoastalEye.com
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CEI 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 or Patient: _____

Address: _____

Phone #: _____ Fax: _____

Release to:

Name of Physician or Patient: _____

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 2043