COASTAL EYE INSTITUTE

Board-Certified Ophthalmologists
Fellowship-Trained Specialists

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

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

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

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

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

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

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

Paul A. Brannan, M.D.
Oculoplastic Surgeon

Selina Lin, M.D.
Retina Specialist, Diabetes
Macular Degeneration

Philip Ames, M.D.
Retina Specialist, Diabetes
Macular Degeneration

Neal Kansara, M.D.
Cataract Surgeon &
Glaucoma Specialist

Benjamin S. Davis
Administrator

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Fax (941) 746-1055

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:_____

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