The Eye Center of North Florida
2500 Highway 77
Panama City, FL. 32405

AUTHORIZATION TO TRANSFER RECORDS

DATE: ____________________

TO: ____
(Doctor/Hospital)

ADDRESS: ____

CITY: ____________________________ STATE: ______________ ZIP: _________

I authorize the release of all records necessary for my eye care needs. Authorization is valid for 60 days.

PATIENT NAME: ____

ADDRESS: ____

CITY: __________________________ STATE: ______________ ZIP: ____________

DATE OF BIRTH: ______ SOCIAL SECURITY NUMBER: ___________________

I request that my records be transferred to:

The Eye Center of North Florida
2500 Highway 77.
Panama City, FL. 32405

__________________________________ ______________________________
PATIENT NAME: PATIENT SIGNATURE