AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Brittany Agee, MD
1034 Riverside Avenue, Jacksonville, FL 32204
Telephone: (904) 354-2114   FAX: (904) 354-2122

Printed Patient Name: ____

Date of Birth: ____ Today's Date: _____________________

I hereby authorize (Name of Physician or Hospital):____

Street Address or PO Box: ____

City, State and Zip Code: ____

FAX:_______________________________________ Telephone:________________________________

To furnish Riverside Eye and Laser Specialists the information indicated below during the period:

From ____ to the present.

Medical records, operative reports, consultations with other physicians,

Visual field testing, glaucoma flow charts, optic nerve photography, OCT studies,

IOL power measurements, laboratory studies, x-ray reports, MRI and CT scanning reports.

Signature of Patient: ____

Signature of Witness: ____

☐ In rare and unusual circumstances, our office sometimes needs medical information sent
to us in an expedited manner. If the box to the left has been checked, we would ask
that you please FAX this information to our office at (904) 354-2114 as soon as possible.
This extra effort on your part is greatly appreciated.

Please send this information to the attention of: ____