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: _____ SS#: _____

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