Ft. Lauderdale
Eye Associates

Personalized care for every patient every day.

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Permission to Release Patient Records from Ft. Lauderdale Eye Associates

Today's Date:_____/_____/_____

Patient Name:_____DOB:____/____/_____

I grant permission to Dr. George Fournier / Ft. Lauderdale Eye Associates to release my patient records to:

_____

_____

_____

_____

The medical findings and treatments disclosed should cover the period from _____ to _____. In initiating this request, I hereby release Dr. George Fournier / Ft. Lauderdale Eye Associates from any laws governing the disclosure of confidential of privileged information.

_____Date:_____

Patient Signature, parent of minor or legal guardian