EYE CONSULTANTS
STEPHEN E PASCUCCI | MD | FACS

RECORDS RELEASE AUTHORIZATION

Date: _____

I hereby authorize _____
to release a complete copy of my medical records including all examination reports, visual field results, corneal topographies, operative reports and lab results to Stephen E. Pascucci, M.D. and Eye Consultants of Bonita Springs, PLLC.

Please forward these records to:
Stephen E. Pascucci, M.D.
c/o Eye Consultants of Bonita Springs, PLLC
24820 Burnt Pine Drive, Ste 4
Bonita Springs, FL 34134
Phone 239.949.2021
FAX 239.949.1500

Thank you.

Patient name: _____

Date of birth: _____

Patient signature: _____

Witness: _____