Stolte Eye Center

Keith B. Stolte, M.D., F.A.C.S
Board Certified Ophthalmologist

PATIENT MEDICAL RECORD RELEASE REQUEST

I, ____, request that my medical records are sent:

From:

Name: ____

Address: ____

City / State / Zip: ____

Phone #: ____

To:

Name: ____

Address: ____

City / State / Zip: ____

Phone #: ____

My medical records dating from ___________________________ to _________________________________

My complete records in your possession, including the test results

Reason for Copy of Medical Records: ____

____

_________________________________ Patient Signature

_________________________________ Date Signed

Due to the high volume of records requested daily by multiple providers and insurance companies, we unfortunately find it necessary to charge for the records that you are requesting. We apologize for any inconvenience this may cause and thank you for your understanding.

The Charge for copying medical records is as follows:

We will charge $1.00 per page for each page up to 25 pages. Every page thereafter will be charged at $0.25.

These charges are in accordance with Florida Statute 455.241 and Florida Administrative Code 61F6.26.003 and 59R. You will be contacted by a member of the Stolte Eye Center staff in regard to the amount due for the copying of your records. Once your payment has been received the copies will be made and the records forwarded to the address requested above within one week's time.

If you have any questions, please feel free to contact the office at the numbers below.

Thank you for allowing us to be of service to you and may we wish you the best health in the future.

10441 Quality Dr. Spring Hill, Florida 34609 Spring Hill, FL 34609

352-666-9990