



Stolte Eye Center  
**Keith B. Stolte, M.D., F.A.C.S**  
 120 Medical Blvd, Ste 100 Spring Hill, FL 34609  
 (352) 666-9990 Fax: (352) 666-1905

## REQUEST TO RELEASE MEDICAL RECORDS

\_\_\_\_\_  
 Patient Name

\_\_\_\_\_  
 Guardian or Authorized Party Name (if applicable)

\_\_\_\_\_  
 Social Security Number

\_\_\_\_\_  
 Date of Birth

I authorize the use and disclosure of my health information as described below:

Information Requested (check one):

- Records for all care at this facility or doctor.
- Records relating to treatment dates from: \_\_\_\_\_ to: \_\_\_\_\_
- Other (Please specify) \_\_\_\_\_

Information to be released  from  to \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

from  to  
 Stolte Eye Center  
 120 Medical Blvd, Ste 100  
 Spring Hill, FL 34609  
 (352) 666-9990  
 Fax: (352) 666-1905

\_\_\_\_\_  
 Patient, P.O.A, or Legal Guardian Signature

**FLORIDA STATUTE: 64B8-10.003**

- (1) Any person licensed pursuant to Chapter 458, F.S., required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records.
- (2) For patients and governmental entities, the reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following:
  - (a) For the first 25 pages, the cost shall be \$1.00 per page.
  - (b) For each page in excess of 25 pages, the cost shall be 25 cents per page.