

MEDICAL INFORMATION RELEASE FORM

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-	City: Phone:		State.	Date of Birth:	Zip:		
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es	st Medical Information F		☐ Center Fo	or Sight	Other (fill in info	ormation below)	
-	Physician/Practice Name	:					
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	City:	State:		Zip:		Phone:	
d M	edical Information TO:						
ent	er For Sight						
	AMARA: 1370 East V	'enice Avenue	, Suite# 205 – Veni	ce, FL 34285 -	941.263.4799 Fa	ax 941.412.0074	
	Sarasota: 2601 South	n Tamiami Tra	il – Sarasota, FL 34	1239 – 941.925.	2020 Fax 941.33	0.2200	
	Venice: 1360 East Ve	enice Avenue -	- Venice, FL 34285	- 941.488.2020	O Fax 941.488.25	03	
	Englewood: 1800 S.						
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At Center For Sight, we consider it a privilege to be entrusted with your care. Please allow 10 business days for processing your request.

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