SUAREZ OPTICAL
Providing Eye Care For Your Family
Since 1971

8100 SW 24 St | Miami, FL 33155 | P 305-265-7676 | F 305-265-5276

www.suarezoptical.com | suarezoptical@gmail.com

Request for Medical Records

Date of Request: _____ / _____ / _____

We, Suarez Optical, Inc. hereby request copies of the below named patient's medical records to be sent to our office. Please include all charts, test results, consultation notes and referrals regarding the below named patient's medical care.
Thank you for your cooperation.
Please contact our office if you need any additional information.

Please submit records via email to suarezoptical@gmail.com or via fax at 305-265-7676.

Patient's Name _____ **DOB:** _____ / _____ / _____

Requesting records to be sent to:

Physician / Establishment _____

Address _____ **City,State,Zip** _____

Phone _____ **Fax** _____

Email _____ **Attention** _____

Patient's Authorization

Patient's Name _____ **DOB:** _____ / _____ / _____
Please Print

Patient's Signature _____

Patient's Guardian _____ **Relation** _____
Please Print

Patient's Guardian Signature _____

Physician's Name _____ **Physician's Signature** _____
Please Print