The Eye Dr.
Records Transfer for Treatment Purposes

Date: ______________________________

To: Dr. ____

Address: ____

City, State Zip: ____

Phone: __________________________ Fax: ________________________

Name of Patient: __________________________________ DOB: _______________

Treatment Dates: (approximately): ____

I hereby authorize the release of my medical records including all prescription information to:

☐ The EYE Dr. - Drs. Grillo & Lenoir, Optometric Physicians
4809 North Armenia Avenue Suite 200 Tampa, FL 33603
813.874.8724 Fax: 813.877.3420 office@theeyedr2020.com

☐ The EYE Dr. - Drs. Grillo & Lenoir, Optometric Physicians
945 E. Brandon Blvd Brandon, Florida 33511
813.662.3937 Fax: 813.662.5367 office@theeyedr2020.com

Signature of Patient or Guardian: _____________________________________

Date: ____

If not patient, Relationship to Patient: _________________________________

Date Sent / Faxed: ________________ By Whom: ______________________