THE SELEM CENTER
OPHTHALMOLOGY & PLASTIC SURGERY
MIAMI eye CENTER
Joseph Selem, M.D.

# REQUEST FOR RECORDS

Dear Doctor:_____

The following individual has asked us to request that his or her medical records be released and forwarded to our office:

Patient Name:_____

Birth Date:_____ Social Security Number:_____

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request for copies of all relevant medical records in your file. Please be sure to include x-ray films and reports.

Thank you for expediting this request. Please send these records to our office address show below.

I hereby authorize the release of all necessary medical records to The Selem Center. I wish for them to be forwarded as soon as possible.

Patient's Signature: _____ Date: _____
(Or parent if patient is a minor)

Patient's Address: _____

City: _____ State: _____ ZIP Code:_____

Signature of Witness: _____

CORAL GABLES LOCATION
814 Ponce de Leon Blvd.
Suite 510
Coral Gables, Florida 33134

MIAMI LOCATION
3850 SW 87th Avenue
Suite 304
Miami, FL 33165

Tel: 305.444.0221 • Fax: 305.444.0223

www.theselemcenter.com
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