MARIANNE GERACI, MD
5185 Castello Dr., Suite 2
Naples, FL 34103
239-963-9827

I hereby authorize:

Dr. / Clinic _____

Address _____

City / State / Zip _____

Telephone _____ Fax _____

to release a copy of my medical records, including visual fields and contact lens information to:

Marianne Geraci, MD
5185 Castello Dr., Suite 2
Naples, FL 34103
Phone: 239-963-9827
Fax: 239-963-9854

Thank you,

Patient Name _____

Patient Address _____

Date of Birth _____

Patient Signature _____

Date _____