



EYE CONSULTANTS
OF BONITA SPRINGS, PLLC

**Stephen E. Pascucci, M.D.
F.A.C.S.**

**Cataract and
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Cornea and External
Disease Specialist**

**Affiliate Assistant
Professor of Ophthalmology
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RECORDS RELEASE AUTHORIZATION

Date: _____

I hereby authorize _____
to release a complete copy of my medical records including all examination
reports, visual field results, corneal topographies, operative reports and lab results
to Stephen E. Pascucci, M.D. and Eye Consultants of Bonita Springs, PLLC.

Please forward these records to:

Stephen E. Pascucci, M.D.
C/o Eye Consultants of Bonita Springs, PLLC
Coconut Professional Center
23451 Walden Center Drive
Bonita Springs, FL 34134
Phone 239.949.2021
FAX 239.949.1500

Thank you.

Patient name: _____

Date of birth: _____

Patient signature: _____

Witness: _____