603 Stanwix St, Suite 150
Pittsburgh, PA 15222

ph & text : 412.471.9838
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appointments@gatewayeye.com

RECORDS REQUEST FORM

Patient Name: ____ Date of Birth: ________________

Address:____

Home #: ________________ Cell #: ________________ Email:____________________________

I hereby authorize Gateway Eye Associates to release my health records to the following:

Name/ Facility: ____

Address:____

Phone #: ________________ Fax#: ________________

□ *Requesting copies sent to patient's address.*

- These records are stored offsite and will take 7-14 business days to be securely transferred. Please allow 2 weeks before attempting to follow-up.
- Additional requests or follow-ups by email, phone or text may cause delays.
- Copies requested to be sent direct to patient have a $50 Fee. Payment must be received prior to processing. Credit card payments can be done online at our website www.gatewayeye.com. Checks and money orders can be mailed to above office address.
- You will be notified when your request begins processing and again, when payment is received. Please select preferred method of communications : □ Phone □ Text □ Email
- Completed forms can be returned by regular mail, emailed, faxed or a text image.

Signature: ____ Date; __________________