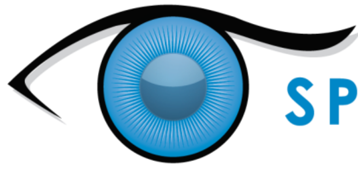

AUTHORIZATION TO RELEASE/REVIEW HEALTH INFORMATION

PATIENT NAME____

DATE OF BIRTH_________________________

I authorize the custodian of the records of_______________________________________
(*Practice name and address*)
____

to release the following health information (*Please check all that apply*)

____	All records	____	Laboratory/Pathology
____	Consultation Notes	____	Progress Notes
____	Operative Reports	____	Admission Notes

These records are for services provided on the following dates:________________________

Please release and send my health information and records listed above to:

Specialized Eye Care

1 Village Square, Suite 190

Baltimore, Maryland 21210

Phone: 410-435-8881 Fax: 410-435-8886

____________________________________ ______________________
Signature of Patient or Representative Date

____________________________________ ______________________
Printed Name of Patient or Representative Representative's Authority to Sign for Patient (i.e., parent, guardian, power of attorney)