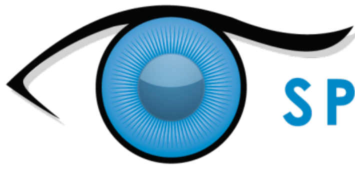

SPECIALIZED EYE CARE

MEDICAL RECORDS RELEASE AUTHORIZATION

NAME____

ADDRESS____

TELEPHONE #____

SSN____________________________________ **DOB**_______________________

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

____

to release the following 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 send the records listed above to:

Name____

Address____

Phone___________________________________Fax_________________________________

This authorization shall expire no later than __________________ and may not be valid for greater than one year from the date of signature for Maryland medical records.

_______________________________________ ________________________

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)