Rockville Eye Associates, PC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name	Date of Birth

I authorize **Rockville Eye Associates, PC**

to release my health information to:

Doctor or Other Recipient	
Recipient Address	
Recipient Fax Number	

Please release the following information:

□ Office notes
□ Surgical reports
□ Diagnostic testing (VFs, OCTs, Topography etc.)

For the period : _____ to _____

Note: If these records contain information about HIV/AIDS status, cancer, diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

_____ _____

Patient Signature Date