Rockville Eye Associates, PC

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name	Date of Birth

I authorize: _____

to release my health information to:

Rockville Eye Associates, PC
3204 Tower Oaks Blvd., #300
Rockville, MD 20852
Fax 301-231-5254

Please include 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