

THE EYE ASSOCIATES GROUP

RYE EYE  GREENWICH EYE  MT. KISCO EYE  DUTCHESS EYE

Today's Date:

I hereby authorize the release of records from _____ to _____, and request that they be transferred to:

Name, address, phone number and fax number of physician or person:

And/or secure email: _____

Patient Name

Date of Birth

Signature of patient or person responsible

Date of Signature

167 Purchase Street
Rye, NY 10580
Tel (914) 921-6966
Fax (914) 921-6498

741 Sergeant Palmateer Way
Wappingers Falls, NY 12590

69 South Moger Avenue
Mount Kisco, NY 10549

4 Dearfield Drive, Suite G1
Greenwich, CT 06830