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