AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

DOCTOR INFORMATION

To: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____

I hereby authorize and request you to release any and all information which you may possess relating to my examinations and illnesses, including psychiatric and/or psychological information and information pertaining to AIDS and/or Human Immunodeficiency Virus testing which may be a part of my medical records.

These records are to be forwarded to:

Center for Ophthalmology & Laser Surgery
Dr. Michael Loeffler or Dr. Malka Davina Kirschenbaum
2100 NE 36th Street, Suite 102
Lighthouse Point, FL 33064-7574
Tel (954) 786-5353 / Fax (954) 786-5340
Email: patricia@oculaser.com

Patient Signature: _____ Date: _____

Witness: _____ Date: _____