Pasadena EYE CENTER

Authorization to Request Release of Medical Records

David E. Hall, MD | Nathan R. Emery, MD | Dennis C. Ryczek, OD

To: _____ Date: _____

_____

_____

Phone/Fax: _____

AUTHORIZATION TO REQUEST RELEASE OF MEDICAL RECORD

I authorize the physicians at Pasadena Eye Center, LLC, to obtain or release any medical records required for the below-referenced patient's continued healthcare on his/her behalf.

_____ _____

Patient's Printed Name Date of Birth

_____

Patient's Address

_____

_____

_____ _____

Patient/Relative/Healthcare Surrogate Signature Relationship to Patient