EYE CENTER

The Eye Center LLC
61 Lincoln Street, Suite 305
Framingham, MA 01702

☎ (508) 620 0017
Fax: (508) 620 0019

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO THE EYE CENTER

Name of the Patient: _____

Patient's Date of Birth: _____

By signing this authorization, I authorize

_____

(**Name of Doctor and/or Practice that currently has your records)**

Dr.'s Phone Number _____ Fax Number: _____
(Please verify the fax number; you will be responsible for any issues in case the fax number written above by you is incorrect)
to transfer the following medical records pertaining to me and Mail or Fax them to The Eye Center.

☐ Exam Notes

☐ Visual Field Test / OCT or other Test results

☐ Photographs

☐ **ALL OF ABOVE**

Signature: _____

Date: _____

OPTIONAL
Complete section below ONLY if the Patient is NOT signing this form

Relationship to Patient (if signer is NOT the patient) _____

Legal Guardian Signature: _____

Legal Guardian Name: _____