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

☎ (508) 620 0017
Fax: (508) 620 0019

AUTHORIZATION TO RELEASE MEDICAL RECORDS FROM THE EYE CENTER

Name of the Patient: ____________________

Patient's Date of Birth: ____________________

By signing this authorization, I authorize the Eye Center to release my records to the following

Practice Name ____________________ **Doctor's Name** ____________________

Mailing Address ____________________

Phone Number ____________________ **Fax Number** ____________________

(Please verify the information above, especially the fax number; you will be responsible for any issues in case the fax number written above by you is incorrect and the records are sent to the wrong location)

☐ 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: ____

The fees for processing the transfer are $5.00 payable before records are released