AUTHORIZATION FOR RELEASE OF EYECARE RECORDS

PATIENT'S NAME ____

Date of Birth ____________________ **Social Security #**___________________________

I authorize Dr. ____***, whose address is***

____

to release a copy of my EYECARE RECORD (or preferably a summary thereof) and I hereby release him/her from all legal responsibility or liability that may arise from this authorization.

SIGNED ______________________________________

WITNESSED __________________________________

DATED _______________________________________

PLEASE SEND RECORD OR SUMMARY TO:

Harry B. Grabow, M.D., P.A.
SARASOTA CATARACT & LASER INSTITUTE
3920 Bee Ridge Road, Building F, Suite A
Sarasota, Florida 34233
PH: 941-921-7744 FAX: 941-921-3783

RR2(8/00)