MEDICAL EYE SERVICES
48 SOUTH GREENLEAF AVE
GURNEE, ILLINOIS 60031
(847) 662-4016
FAX (847) 662-6982

MEDICAL RECORD RELEASE

Patient Name: _____

_____
Address City, State, Zip

_____
Birth date Phone

I authorize

_____

_____

_____

To release information regarding my medical care and treatment to:

_____

_____

_____

Information to be release:

_____ All eye care and treatment records include _____ Operative reports

_____ Fluoro Angiogram _____ Contact Lens Specs and "K" readings

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records.

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Signature of Patient _____ Date _____

(If signed by person other than patient, state relationship and authorization to do so)

Authorized Signature _____ Relationship _____

09/2007