RECORDS RELEASE AUTHORIZATION

I hereby authorize release of copies or a summary of records pertaining to the eye care of:

_____ _____

Name of Patient **Date of Birth**

TO BE SENT TO:

Paul Phillips Eye & Surgery Center
6B Minneakoning Road
Flemington, NJ 08822
Fax: 908-968-3239

Signed:_____
Relationship to Patient:_____
Date:_____