PAUL PHILLIPS EYE & SURGERY CENTER

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**

From:_____

_____

_____

Fax: _____

TO BE SENT TO:

Paul Phillips Eye & Surgery Center

6B Minneakoning Road

Flemington, NJ 08822

Fax: 908-968-3239

Signed:_____

Date:_____

Relationship to Patient:_____

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