Authorization to Disclose Health Information

Patients Name ________________________________

Date______________

Address____

____

Patient
Signature____

__________________________________ Witness

Signature_____________________________ (If not patient) (If minor, Parent or Guardian)

I hereby authorize:
Please indicate name of Other Physician:

____

Address____

____

Phone __________________________________
Fax____________________________________

To release the complete history records in your possession, concerning my illness and/ or treatment during the period from
_______________________ to ________________________

Release To:

Fifth Avenue Eye Care and Surgery

1115 Fifth Ave, New York, NY 10128

(212)517-4500 Fax (212)212-517-4116