

## **Record Release Authorization**

This form is provided for your convenience. After completing this form, please mail or fax the completed form to your previous eye care specialist **prior** to your appointment.

Date: \_\_\_\_\_

### **PATIENT INFORMATION** (Print Carefully):

Patient's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Other information requested: \_\_\_\_\_

### **I HEREBY AUTHORIZE** (previous eye care specialist information)

Dr. \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To fax a complete copy of my medical records to

Dr. Howard Sherman

202 Raritan Avenue

Highland Park, NJ 08904

Phone: 732-247-1167

Fax: 732-846-3200

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's or Authorized Person's Signature

Print the Name of the Person Signing: \_\_\_\_\_

Print Your Relationship to the Patient: \_\_\_\_\_