RECORDS RELEASE AUTHORIZATION

DOCTOR OR HOSPITAL: ____

ADDRESS: ____

CITY: ___________________________ STATE: __________ ZIP: _____________________

PHONE: ______________________________ FAX: ___________________________________

I hereby authorize and request you to release to:

CYNTHIA L. ALLEY, M.D.
PEDIATRIC OPHTHALMOLOGY & STRABISMUS ASSOCIATES
P.O BOX 253
NEWTOWN SQUARE, PA 19073
T: (610) 347-7672 F: (610) 347-7673

The complete medical records in your possession concerning my eye examinations, including all operative reports.

PATIENT NAME: ___________________________________ D.O.B.: ____________________________

ADDRESS: ____

CITY: ____________________________________ STATE: _____________ ZIP: __________________

SIGNATURE: ____

RELATIONSHIP TO PATIENT: _____________________________________ (If patient is a minor)