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Glaucoma
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GENSTLER EYE CENTER

MEDICAL RECORD RELEASE AUTHORIZATION

I AUTHORIZE

_____ **MD, DO, OD**

_____

_____

(Address)

I authorize you to release to **Genstler Eye Center** all of my office records (including, but not limited to, diagnosis, office notes, laboratory results and letters) of my examination and treatment.

Indicated below the specific information you want released. THANK YOU.

_____ Written Report (If unavailable, all patient records)
_____ All Patient Records including images
_____ Contact Lens Specifications, Refraction and Vision
_____ Visual Fields
_____ Other_____

_____ (Name)	_____ (Date of Birth)
_____ (Address)	_____ (City, State, Zip)
_____ (Patient's Signature)	_____ (Date Signed)
_____ (Witness)	_____ (Date Signed)

Records Release **TO** Genstler Eye Center