MONTGOMERY EYE
PHYSICIANS & SURGEONS

Records Release Authorization

Tel: (301) 881-5888 | Fax: (301) 881-2945

I hereby authorize the release of all of my records or copies of such from:

_____

_____

_____

To be released to: Montgomery Eye Physicians & Surgeons | Drs. Kane, Park & Zeller

Please send us:

☐ All exam/visit notes including visual fields & OCT's.

☐ Last_____visit/exam notes. Please include visual fields.

Patient Name:_____

Date of Birth:_____Social Security #:_____-_____-_____

Patient Address:_____

_____

Signature:_____Date:_____

NOTICE OF CONFIDENTIALITY

IF MEDICAL RECORD INFORMATION HAS BEEN FAXED TO YOU, BE AWARE THAT HIPAA AND MARYLAND STATE LAWS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT WTRITTEN CONSENT OF THE PATIENT OR AS OTHERWISE PERMITTED UNDER THE HIPAA REGULATIONS OR STATE LAW. A GENERAL AUTHORIZAITION FOR RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIEMT FOR THIS PURPOSE. MEDICAL RECORDS INFORMTION RECEVEIED DOES NOT CONTAIN PHYSICIAN SIGNATURE. A SIGNED COPY OF THIS REPORT IS MAINTAINED IN THE PATIENTS RECORD AT THE ABOVE ADDRESS. IF YOU RECEIVE THIS CIMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY AT THE TELEPHONE NUMBER ABOVE.