STONE OAK OPHTHALMOLOGY CENTER

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REQUEST FOR MEDICAL RECORDS

Please send a copy of this patient's complete ophthalmic to: Stone Oak Ophthalmology Center or OTHER medical records

I hereby authorize: _____

_____

_____

to disclose the above information to Allison Young, M.D.// Jana Waters, M.D//Vasudha Panday, M.D., in furtherance of this authorization, I do hereby waive all provisions of law and privileges relating to the disclosures hereby authorized.

Dated this _____ day of _____, 20_____

_____
Patient's name (please print)

_____
Patient's Date of Birth

_____
Patient's signature (or responsible party)