Bedminster Eye & Laser Center, P.A.
P.O. Box 103
Bedminster, NJ 07921
908-781-2020
908-781-7505 (fax)

RELEASE OF MEDICAL RECORDS

RE: ______________________________

Date of Birth: ______________________

Social Security #: __________________

I hereby authorize the release of copies of my medical records to:

TO: ____

ADDRESS: ____

CITY, STATE, ZIP: ____

PHONE/FAX #: ____

____
Patient Name (Please Print)

____
Patient Contact #

____
Patient Signature and Authorization

____
Date (MM/DD/YY)

____
Patient Address