TO: ______________________________

ADDRESS: ______________________________

CITY, STATE, ZIP: ______________________________

PHONE/FAX #: ______________________________

REQUEST FOR MEDICAL RECORDS

RE: ______________________

Date of Birth: ____________________

Social Security #: _______________

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

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

Please include:

- ☐ **Medical, Therapeutic and Surgical Record**
- ☐ **Visual Fields**
- ☐ **Stereo Disc Photos**
- ☐ **OCT Record**
- ☐ **HRT Record**

______________________________ ______________________

Patient Name (Please Print) **Patient Contact #**

______________________________ ______________________

Patient Signature and Authorization **Date (MM/DD/YY)**

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Patient Address