AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____

DOB: ______________________________ SS#: ______________________________

I hereby authorize ____ (physician or facility)

to release my medical records to:

AD ASTRA EYE
17795 W 106TH ST, SUITE 202
OLATHE, KS 66061
785-424-8805 (phone) 913-712-9808 (fax)

Covering period of treatment FROM: _________________ TO: _________________

____ _________________________

Patient or Legal Representative Signature Date

CONFIDENTIALITY NOTICE:
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