

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____

I hereby authorize _____ (physician or facility) to release my medical records to:

AD ASTRA EYE, LLC
1429 Oread West St., Suite 110A
Lawrence, KS 66049
785-424-8805 (phone) 913-229-7030 (fax)

Covering period of treatment FROM: _____ TO: _____

And/or Last Clinic Notes, Visual Field, and OCT

Patient or Legal Representative Signature

Date

CONFIDENTIALITY NOTICE:

The information contained in this facsimile message is attorney privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return the original message to us at our address via the United States Postal Service. Thank You.