LALIN EYE
CATARACT & RETINA

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**DOCTOR INFORMATION**

To: _____ Date: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

**PATIENT INFORMATION**

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____

I hereby authorize and request you to release any and all information which you may possess relating to my examinations and illnesses, including psychiatric and/or psychological information and information pertaining to AIDS and/or Human Immunodeficiency Virus testing which may be a part of my medical records.

**PLEASE FORWARD RECORDS TO:**

Lalin Eye Attn: Sean Lalin, MD

330 South St Ste 1, Morristown NJ 07960 Fax: 973.871.2000

500 Willow Grove St, Hackettstown, NJ 07840 Fax: 908.813.0255

Questions? Call us at 973.559.2442

Patient Signature: Date: