

Permission for Release of Patient Medical Records from  
**Golden Eye Surgeons and Consultants**

**Doctors For Visual Freedom**

875 North Michigan Avenue Suite 1550

The John Hancock Center

Chicago, IL 60611

Tel: 312-291-9680

Fax: 312-291-9957

**Patients Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**I hereby authorize the release my medical records to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient's signature:** \_\_\_\_\_

**Date** \_\_\_\_\_

There may be a charge for copying of records