

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

5201 N. Harlem
Chicago, IL 60656
Tel: 773-774-2102
Fax: 773-774-3581

Patients Name: _____

DOB: _____

I hereby authorize the release my medical records from:

Patient's signature: _____

Date _____

Thank you for your prompt assistance.