Barenburg Eye Associates, Inc.

100 Park Avenue
Baltimore, Maryland 21201
(410) 727-0285

RELEASE TO ACQUIRE MEDICAL RECORDS

PLEASE PRINT CLEARLY

I, ____, hereby authorize (name, address, phone of present physician or other health care provider on lines below)

____

____

____

to release any medical information pertaining to me to: (check one)

❒ 100 Park Avenue
Baltimore, MD 21201
(410) 727-0285
Fax No. (410) 727-7780

❒ 2300 Garrison Boulevard
Baltimore, MD 21215
(410) 624-7660
Fax No. (410) 362-1042

❒ 9051 Baltimore National Pike
Ellicott City, Maryland 21043
(410) 465-4080
Fax No. (410) 461-8650

❒ 720 Wise Avenue
Dundalk, MD 21222
(410) 388-0005
Fax No. (410) 388-2922

❒ 1838 Greene Tree Road, Ste 225
Pikesville, MD 21208
(410) 653-0200
Fax No. (410) 602-9909

Dated _________________ Patient Signature ____________________________________

Social Security # ___________________________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient __________________________

Print Name ___________________________________

Source of Authority:

____