Record Release Authorization

This form is provided for your convenience. After completing this form, please mail or fax the completed form to your previous eye care specialist **prior** to your appointment.

Date: _____

PATIENT INFORMATION (Print Carefully):

Patient's Name: _____ Date of Birth _____

Patient's Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Home: _____ Cell: _____ Work: _____

Other information requested: _____

I HEREBY AUTHORIZE (**previous** eye care specialist information)

Dr. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

To fax a complete copy of my medical records to

Dr. Howard Sherman
202 Raritan Avenue
Highland Park, NJ 08904
Phone: 732-247-1167
Fax: 732-846-3200

Signature: _____ Date: _____
Patient's or Authorized Person's Signature

Print the Name of the Person Signing: _____

Print Your Relationship to the Patient: _____