Family Eyecare of Roswell
Maurice E. Zadeh, OD and Associates

AUTHORIZATION TO RELEASE MEDICAL RECORDS

_____ _____ _____
(Patient Name) (Maiden Name, if applicable) (Patient DOB)

Dr. Maurice E. Zadeh requests and authorizes _____ to release
(office or doctor holding previous records)

any medical records and information belonging to the patient named above. Family Eyecare of Roswell is requesting records from the following office:

_____
(Practice Name) (Doctor's Name)

_____
(Address) (State) (Zip)

_____
(Practice Phone Number)

This request applies to healthcare information relating to the following:

- Treatment or condition: _____
- Range of dates: _____
- All records on file: _____
- Other: _____

_____
(Patient Name / Print)

_____
(Patient Signature) (Date)

This request form expires in 90 days.