associates in Ophthalmology
Your eyes, our vision

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248.855.1020 Phone
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Date: _____

I hereby authorize the release of my complete medical records in your possession.

TO:

_____

_____

_____

_____

FROM: **Associates in Ophthalmology, P.C.**
27555 Farmington Road
Farmington Hills, MI 48334
(248) 855-1020 Fax: (248) 855-2639

Patient: _____
(Please Print)

Date of Birth: _____

Signature: _____

Witnessed: _____

Thank you for your cooperation in this matter.

***** There is a fee for record copying.**