

# Authorization for Release of Medical Records

Patient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ SSN: \_\_\_\_\_

This will authorize:

Business Name/Phone: \_\_\_\_\_

Business Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

To release my medical records to:

**Milliken Eye Care  
7 New Driftway  
Scituate, MA 02066**

Patient Pickup

Via fax: 781-544-0009

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Signature of Patient

Date