In order to help us provide the best possible eye care for you, you may want to complete this page and request your records from your previous eye care provider. Please circle the office location where you have scheduled your appointment and mail or fax this signed and dated form to you prior doctor.

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PHYSICIANS EYE CARE & LASER CENTER

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10132-D Balt.Nat'l. Pike
Ellicott City, MD 21042
410-480-9966
fax 410-480-9985

To:_____

_____

_____

I hereby authorize you to release to Physicians Eye Care and Laser Center any information including the diagnosis and records of any treatment or examination rendered to me during the period from_____to_____

Please include, if applicable, information regarding corrective lenses and copies of any visual field tests.

_____ _____

Signature Witness

_____

date