

BOSTON EYE CARE CONSULTANTS

Robert A. Lytle, MD ~ Eye Physician and Surgeon

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(508) 771-6447 ~ FAX: (508-775-5104

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

DOB: _____

Phone: (H) _____ (M) _____

Address: _____

*I authorize: **Boston Eye Care Consultants ~ (508) 771-6447**
to release my confidential health information to:*

Facility _____ Physician _____

Phone: _____ FAX: _____

Address: _____

Name: _____

Signature _____ Date: _____