THE EYE CLINIC
F. PAYDAR, M.D.
Board Certified Ophthalmologist

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name:_____ DOB:_____

I _____, authorize: _____
to release any and all medical records to Dr. Farshid Paydar. Please fax all records to _____ location listed above.

In initiating this request, I hereby release my Practitioner from any laws governing the disclosure of confidential or privileged information.

_____ _____
Patient Signature Date

_____ _____
Witness Date