

**THE EYE CLINIC**

*Farshid Paydar, MD - Board Certified Ophthalmologist*

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**AUTHORIZATION TO RELEASE  
MEDICAL RECORDS**

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

I \_\_\_\_\_, authorize The Eye Clinic to release any and all medical records to \_\_\_\_\_.

Please fax all records to: \_\_\_\_\_.

Patient was last seen in our office on \_\_\_\_\_. If you have any questions, please call one of our locations 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