Request for Medical Records

Jonathan H. Talamo, M.D.
Stephanie A. Paris, OD

Name: _____
first middle last

Date: _____

To: _____
Doctor or Hospital to release information

_____
Street

_____
City State Zip Code

I hereby authorize and request that my medical record be released to:

Dr. _____ (recipient of information)
Reservoir Place
1601 Trapelo Road
Suite 184
Waltham, MA 02451
ATTN: Medical Records

☐ To save time, please fax my record to:

781-890-2507

Please release information **pertaining to my ocular health**, including examination, diagnosis and treatment rendered to me by your office. Please forward records no later than _____.
(date of appt)

_____ _____
Patient's Name (Please Print) Date of Birth

_____
Street

_____
City State Zip Code

I am aware that I may revoke this authorization in writing, prior to information being released. I acknowledge that information released per this request is subject to re-disclosure by Cornea Consultants, and may no longer be protected under HIPAA rules

_____
Patient's Signature (or Authorized Representative) Date

☐ I am an personal representative for the above named patient, and have the authority to act on behalf of this individual.

_____ _____
Witness' Signature Date Relationship to Patient