NORTH BAY EYE ASSOCIATES

Jason Bacharach, MD
Glaucoma Consultation &
Anterior Segment Surgery

William Bartlett, MD
General Ophthalmology &
Anterior Segment Surgery

Michael A. Saidel, MD
Cornea Consultation &
Anterior Segment Surgery

Jasdeep Sabharwal, MD, PhD
Glaucoma &
Cataract Specialist

Emil Shieh, MD
General Ophthalmology &
Anterior Segment Surgery

Rona Silkiss, MD, FACS
Ophthalmic Plastic &
Reconstructive Surgery

Roger D. Weeks, MD
General Ophthalmology

Stephen Atallah, OD
TLG Certified Optometry

Antonio F. Moran, OD
Comprehensive Optometry

MEDICAL RECORDS RELEASE FORM

AUTHORIZATION TO RELEASE RECORDS TO:

NAME/MEDICAL PRACTICE _____

PHONE #:_____ **FAX #:** _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE**_____

Specify Records:
I hereby authorize you to release my medical records, including all medical/vision records and any contact lens information available.

Duration:
This authorization shall become effective immediately and shall remain in effect for one year from the date of signature.

Revocation:
I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Redisclosure:
I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Patient Name _____ **Date of Birth** _____

Signature of Patient/Responsible Party _____ **Relationship to Patient** _____

Date _____

Patient has a right to a copy of this authorization