



Records Release Request

Date: _____

To: _____, M.D.

Address: _____

Phone #: _____

Fax #: _____

I hereby authorize the release of the following information:

_____ Lab Tests _____ Other _____ Complete File

_____ Summary of Consult _____ Office Records

Patient Name: _____

Patient Address: _____

Social Security Number: _____ Date of Birth: _____

Patient Signature: _____

Witness: _____

Forward information to (Please Circle)

Azar Eye Institute
Medical Records
31519 Winter Place Parkway
Salisbury, MD 21804
410-546-2500
410-546-5005 (fax)
William.martin@azareyeinstitute.com Email

Azar Eye Institute
Medical Records
116 East Front Street
Laurel, DE 19956
302-875-8991
302-875-8996 (fax)
William.martin@azareyeinstitute.com Email