PATIENT INFORMATION RELEASE AUTHORIZATION

Patient Full Name: ____
(First) (Middle) (Last)

Date of Birth: ________________ SS#_________________Telephone: (   )____________

Address:____
(Street) (City) (State) (Zip)

I, ______________________________, hereby authorize ___________________________

____________________________, (_____)_________________, to release information contained in my patient medical records to the following facility:

Bergman Porretta Eye Center
Ronald Bergman, M.D./Eric Belcarz, O.D./Michael Greenley, MD/Zach Bergman, M.D.
29990 Northwestern Highway
Farmington Hills, MI 48334
(248) 538-6463 / FAX (248) 516-1200

The purpose for such disclosure is:

____patient request ____continuation of care _____insurance _____attorney

____disability ____workman's compensation ____other ________________

Dates of records to be released: ____________________to_____________________

____ ________________________
Signature Date

____ ________________________
Relationship to patient Date

____ ________________________
Witness Date

Patient Return Appointment __________________

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OFFICE USE ONLY

Date Record Sent __________________ Date Record Received __________________