KwiatEye
& LASER SURGERY

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REQUEST FOR MEDICAL INFORMATION

DATE OF REQUEST: _____

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

REQUESTED MEDICAL INFORMATION:

_____

_____

_____

REQUEST MEDICAL INFORMATION TO:

KWIAT EYE AND LASER SURGERY
100 HOLLAND CIRCLE DRIVE
AMSTERDAM NY, 12010

AUTHORIZATION FOR RELEASE:

I HEREBY AUTHORIZE _____

TO FURNISH COPIES OF MY PAST MEDICAL RECORDS AND/ OR EYE RECORDS TO KWIAT EYE AND LASER SURGERY.

PATIENT'S SIGNATURE: _____

WITNESS: _____