GLAUCOMA PLUS EYECARE
PREMIER SERVICE

Anshu P. Sinha, M.D.

Authorization For Release of Medical Records

To: Glaucoma Plus Eye Care, LLC
10400 Little Patuxent Parkway
Suite G2
Columbia, MD 21044
Phone: (410) 715-2212; Fax: (410) 715-2214

Patient Name: _____

Patient Date of Birth: _____ SSN: _____

I hereby authorize and request

Doctor and/or Practice Name: _____

Phone # _____ Fax # _____

Address: _____

to release any and all medical records to Glaucoma Plus Eye Care, LLC.

Please include:

- ❑ Visual Fields
- ❑ Images (OCT, HRT, Fundus Photos, etc.)
- ❑ Labs (Blood Work, CT, MRI, etc.)
- ❑ Other: _____

Please fax all records to 410-715-2214 or mail if over 20 pages.

_____

Patient Signature (or person authorized to sign for patient) Date
Relationship to patient: _____

_____

Witness Signature Date