Anshu P. Sinha, M.D.

Authorization For Release of Records

Patient Name: ____

Patient Date of Birth: ___________________ SSN: ___________________

I hereby authorize and request Glaucoma Plus Eye Care, LLC to release any and all medical records to:

Doctor and/or Practice Name: ____________________________________

Phone # _______________________ **Fax #** _________________________

Address: ____

Please allow 5 business days for all records to be sent.

____

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

Relationship to patient: _____________________

____

Witness Signature Date

Anshu Sinha, M.D., FRCSC 10400 Little Patuxent Pkwy, Suite G2, Columbia, MD 21044
(Phone): 410-715-2212 (Email): info@glaucomaplus.com