

EYECARE 20/20

RETINA & VISION CENTER



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Harahan - Mandeville - Slidell
1-800-680-3932
www.EyeCare2020.org

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION:

Patient's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

I, hereby authorize and request EyeCare 20/20 Retina and Vision Center

(Select location)

- Harahan:** 1939 Hickory Ave, Ste 101, Harahan, LA 70123 Fax: (504) 738-3456
- Mandeville:** 2 Sanctuary Blvd, Ste 303, Mandeville, LA 70471 Fax: (985) 624-6613
- Slidell:** 1185 Robert Blvd Slidell, LA 70458 Fax: (985) 641-2790

to RELEASE or RECIEVE *(circle one)* medical records to/from:

(Name of Physician or Facility)

Address

Phone

Fax

Signed: _____
Patient or Authorized Representative

Today's Date