AUTHORIZATION OF MEDICAL RECORDS RELEASE

1. **Patient Information**

   Name: ___________________________________

   Address: __________________________________

   SSN: _____________________________________

   Date of Birth: ______________________________

2. **Authorization for Release**

   I, ____hereby authorize Landa and Landa
   (Patient, or legal guardian)
   Eye Care to release, disclose, and deliver a copy of my medical record to my home.

   Today's Date: ______________________________

3. **Patient Home Address**

   Street Address: ____________________________

   City: _____________________________________

   State:_____________________________________

   Zip Code: _________________________________

4. **Medical Records Retrieval Rate**

   There is a $50 fee that is payable by check. Please attach check to this form.

5. **Mail this form and check to:**

   Landa & Landa Eye Care, LLC
   Medical Records Request
   PO Box 61385
   Savannah, GA 31419

Please allow up to 20 business days to receive medical records.