



Records Release Authorization

Tel: (301) 881-5888 | Fax: (301) 881-2945

I hereby authorize the release of all of my records or copies of such from:

Montgomery Eye Physicians & Surgeons | Drs. Kane, Park & Zeller

To be released to:

All visit notes including visual fields & OCT's

Last _____ exam/visit notes

Patient Name: _____

Date of Birth: _____ Social Security #: _____ - _____ - _____

Patient Address: _____

Signature: _____ Date: _____

NOTICE OF CONFIDENTIALITY

IF MEDICAL RECORD INFORMATION HAS BEEN FAXED TO YOU, BE AWARE THAT HIPAA AND MARYLAND STATE LAWS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT WRITTEN CONSENT OF THE PATIENT OR AS OTHERWISE PERMITTED UNDER THE HIPAA REGULATIONS OR STATE LAW. A GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE. MEDICAL RECORDS INFORMATION RECEIVED DOES NOT CONTAIN PHYSICIAN SIGNATURE. A SIGNED COPY OF THIS REPORT IS MAINTAINED IN THE PATIENTS RECORD AT THE ABOVE ADDRESS. IF YOU RECEIVE THIS COMMUNICATION IN ERROR, PLEASE NOTIFY US IMMEDIATELY AT THE TELEPHONE NUMBER ABOVE.