The MACULA CENTER
Dana M. Deupree, M.D., F.A.C.S.

RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY COMPLETE MEDICAL RECORD TO BE RELEASED FROM:

_____

Name of Doctor / Hospital / Clinic

_____

Address City State ZIP

_____

Telephone Number

_____

FAX

SEND TO:

_____

Name of Doctor / Hospital/ Clinic

_____

Address City State ZIP

_____

Telephone Number

_____

FAX

Patient Signature X_____ Date _____

PRINT: Patient Name _____ S.S.#_____

Patient Address _____

Telephone _____ Date of Birth _____

Chart Number _____

Witness Signature _____ Date _____