SOLOMON
EYE ASSOCIATES
PHYSICIANS & SURGEONS

OPHTHALMOLOGY
OPHTHALMIC SURGERY
STEPHEN M. SOLOMON, M.D.
JONATHAN D. SOLOMON, M.D.
www.solomoneyeassociates.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: _____ **name of doctor**

RE: Patient Name: _____

Date of Birth: _____

The undersigned hereby authorize and request you to provide a copy of the above referenced patient's complete medical record to the party below. Please send records attention: **VIA FAX 301-464-5455**

Jonathan D. Solomon, M.D.

Stephen M. Solomon, M.D.

This authorization is valid for:

_____ Any and all related to past and present medical histories, diagnosis, and treatments.

_____ The medical records concerning the period from _____ to _____

I understand that the medical records released may contain information related to HIV status, AIDS, sexually transmitted disease, alcohol and/or mental health service, and I hereby authorize the release of this information.

This authorization for disclosure is valid for a period of one year and may be withdrawn by me at anytime except during an action taken in response thereon.

_____ _____
Patient or authorized representative DATE

_____
Signature

14999 Health Center Dr | Suite 108 | Bowie, MD 20716 | T: 301.464.1885 | F: 301-464-5455
7500 Hanover Pkwy | Suite 101B | Greenbelt, MD 20770 | T: 301-982-4565 | F: 301-982-4252