dupage ophthalmology

AUTHORIZATION TO RELEASE INFORMATION
Reason for Request: Transferring Care to a New Physician

Name_____
Last First Middle initial
Address_____
Street City State Zip
Phone ( ) _____Date of Birth_____ SSN_____

I authorize _____ to release medical
(Doctor's name)
records to:

DuPage Ophthalmology, SC
Balaji Gupta,MD Sheridan Lam, MD Sujaya Rupani, MD
2500 S Highland Ave, Ste 110
Lombard, IL 60148
Phone: 630-495-2220
Fax: 630-495-2279

_____ No limitations
or (check any of the following)

_____ Do not include information related to the following:
_____ HIV/AIDS
_____ Mental Health
_____ Substance Abuse

_____ Any medical record from other physicians or providers

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed_____Date_____
(If not patient, state relationship)