PREMIER
Eye Care & Surgery, Ltd
Joseph P. Kiernan MD, Medical Director

RECORDS RELEASE AUTHORIZATION

DATE: _____PT ACCT #_____

PATIENT NAME: _____DATE OF BIRTH: _____

PHONE NUMBER: _____

I _____, HEREBY AUTHORIZE AND REQUEST PREMIER EYECARE & SURGERY TO RELEASE THE MEDICAL RECORDS FOR THE ABOVE MENTIONED PATIENT TO: SELF ☐ (check box for self) OR TO:

NAME: _____

ADDRESS: _____

PHONE: _____FAX:_____

SIGNATURE: _____

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FOR OUR RECORDS

DATE MAILED/FAXED/PICKED UP ON: _____

GIVEN/SENT BY: _____

LAST EXAM FOR FREE ☐ OR NUMBER OF PAGES: _____

COST: _____

(*Copy of last exam can be requested at no charge. If more records are needed there will be a per page fee.)

Fax to Barrington 1-847-382-3424 (Mon, Wed, Thurs) or Buffalo Grove 1-847-459-7575 (Tuesday & Friday)