Release of Medical Records

I _____ whose Date of Birth is

_____ give authorization for

Previous Office Name: _____

Previous Office Address: _____

_____

Previous Office Phone Number: _____

Previous Office Fax Number: _____

to release my records to:

Watts Eye Associates, LLC
Dr Chad E McDonald
Dr Katharine D Sullivan
33 Low Street
Newburyport, MA 01950
Office Phone: 978-462-2020
Office Fax: 978-462-4263

Date: _____

Signature: _____