# BRASS EYE CENTER

Dear Dr, N/P, P/A:_______________________________________________

Street Address: ____________________________________________________

City____________________________ State___________ Zip Code__________

MD Phone#: _________________________ Fax#:________________________

Please release my entire medical record to Brass Eye Center. _____Yes ______ No

If I answered no; release only the information indicated below:

_____________________________________________________________________

_____________________________________________________________________

Patient Name: __________________________________________

DOB: ___________________________ SS#:_____________________________

Please send to: Brass Eye Center
Capital Region Health Park
713 Troy Schenectady Road
Suite 135
Latham, NY 12110-2454
Fax: (518) 782-7820

Additional Comments: __________________________________________________

Patient Signature: _____________________________________________________

Guardian Signature if indicated: ___________________________________________