

DAVID S. GENDELMAN, M.D.
Diabetic/Macular Degeneration/Retina Specialist

IOANNIS P. GLAVAS, M.D.
Oculoplastics

SERGEY M. URMAN, M.D.
Cataract Surgery/External Disease

PHILLIP M. GENDELMAN, M.D.
Glaucoma/General Ophthalmology

JASON E. BRENNER, M.D.
Cataract Surgery

ALEC J. SMAIL, O.D.
Contact Lens Specialist

ROBIN F. STEINBERG, M.D.
Neuro-ophthalmology/General Ophthalmology

RODNEY IMMERMAN, O.D.
Low Vision Specialist

DEBORAH E. ZUCKERMAN, M.D.
Pediatric Ophthalmologist/General Ophthalmology

EYE ASSOCIATES, P.C.
Patient Authorization to Release Healthcare Information

Patient Name: _____ **Date of Birth** _____
I authorize _____ (Name of Provider)
_____ (Address)

To release the following health information:

_____ **Medical Records** _____ **Other, Please specify:** _____

To: _____ (Name of recipient)
_____ (Address of recipient)

Reason for Request? _____ **Insurance** _____ **2nd Opinion** _____ **Moving** _____ **Other:** _____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient, and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the covered entity has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy officer at the covered entity.

Signed by: _____ (Signature of patient/legal guardian) _____ (Relationship to Patient)

_____ (Print Patient's name) _____ (Print Name of Legal Guardian)

Date _____

Records can take two weeks to prepare: I would like to _____ **Pick up** _____ **Mail**

Burlington Eye Associates
172 Cambridge Street
Burlington, MA 01803-2985
781-272-4944

Woburn Eye Associates
Baldwin Green Common
Woburn, MA 01801
781-933-0907

Regional Eye Associates
500 Salem Street
Wilmington, MA 01887
978-658-2880

Arlington Eye Physicians
366 Mass Ave.
Arlington, MA 02474
781-646-2020