Kristin Story Held, M.D.

OPHTHALMOLOGY * OPHTHALMIC SURGERY

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REQUEST FOR MEDICAL RECORDS

Date:_____

Please send a copy of this patient's complete ophthalmic records including visual fields and fluorescein angiography (if performed) to **Kristin Story Held, M.D.**

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize _____

_____

to disclose the above information to **Kristin Story Held, M.D**., in furtherance of this authorization, I do hereby waive all provision of law and privileges relating to the disclosures hereby authorized.

Dated this_____day of _____, 20_____

_____
Patient's name (please print)

_____
Patient's signature (or responsible party)

_____
Patient’s Date of Birth