Northwest Eye Physicians

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PLEASE PRINT

Dr.: _____ Phone #: _____

City: _____ State: _____ Zip: _____ Fax: _____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF MY MEDICAL INFORMATION TO:

( ) Christopher F. Wood, M.D.
( ) Augustine Hong, M.D.
( ) Danial Asim, O.D.
( ) Adam Prickett, M.D.
( ) Puja Desai, O.D.

At 1588 N. Arlington Heights Road
Arlington Heights, IL 60004
Phone: (847) 392-9220 FAX: (847) 392-9252

All Records _____ From _____ to _____
Date Date

PLEASE PRINT

Patient's Name _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

_____ _____
Signature of Patient/Parent of Minor/Legal Representative Date