

AUTHORIZATION TO RELEASE RECORDS

I authorize: Princeton Family Eye Care
Bindi A. Desai, OD
701 W Princeton Dr.
Princeton, TX 75407

Phone (972) 734-9119

Fax (833) 627-3517

to release copies of my medical records to : _____
Name of Business

Address

City State Zip

Patient's Name: _____ Date Of Birth: ___/___/_____

Patient's Address _____
Address

Address

City State Zip

Date of Request: _____

PATIENT SIGNATURE

WITNESS

Notes: _____

