THE MEDICAL EYE CENTER

DR. GAGAN SINGH

19719 EXECUTIVE PARK CIRCLE
GERMANTOWN, MD 20874
Phone: 301-528-4500
Fax: 301-528-4501

Records Release

Date:

To:

Fax:

I hereby authorize you to release any and all information, including the diagnosis and records of any treatment or examination I received, to The Medical Eye Center.

_____
Signature

_____
Patient's Name

_____
SSN or DOB

_____
Address

_____
City, State, and Zip

¡ 1st Request

Date Faxed: _____
Time Faxed: _____
Initials: _____

¡ 2nd Request

Date Faxed: _____
Time Faxed: _____
Initials: _____

¡ Received

Date: _____