



UNIVERSITY EYE SPECIALISTS

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**Authorization for Release of Medical Record Information
from University Eye Specialists**

Patient Name:
Date of Birth: _____ Social Security#: _____
Address:
City: _____ State: _____ Zip Code: _____
Telephone #: _____

I request and authorize University Eye Specialists to release to:

Doctor:
Address:
City: _____ State: _____ Zip Code: _____
Telephone #: _____ Fax #: _____

All of my ophthalmology (eye) records, including progress notes, visual fields, operative reports and correspondence.

The State of Illinois specifies the fee to copy and send your records:

Your chart has _____ pages.

Pages 1-25 (flat rate)	\$20.00
Pages 26-50 (\$0.57 per page)	\$ _____
Pages 50+ (\$0.29 per page)	\$ _____
Handling fee	\$ _____
Total	\$ _____

I authorize University Eye Specialists to charge the credit card that is on file.

Signature: _____ Date: _____