AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize: Newman and Taub Cataract and Surgery Center
Dr. Gordon H. Newman, M.D.
Dr. Larry R. Taub, M.D.
Dr. Dain B. Brooks, M.D.
5744 LBJ Freeway, Suite 150
Dallas, TX. 75240
(972) 392-2020 fax (972) 392-4054

To release full details of the medical care and treatment of:

Patient name: _____

S.S. # _____

D.O.B._____

TO:

Name of Doctor/Facility_____

Address _____

_____

_____

Phone: _____ Fax:_____

(I authorize a facsimile of this form/signature in lieu of original)

Patient Signature _____Date_____

Faxed forms must be accompanied by a Picture ID with a signature.