UNIVERSITY EYE SPECIALISTS

LISA F. ROSENBERG, MD
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GINA PIPER, OD

Authorization for Release of Information

Name:		
Date of Birth:		
Address:		
City:	**State:**	**Zip Code:**
Telephone #:		

I request and authorize:

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

To furnish to **University Eye Specialists** all of my ophthalmology (eye) records, including progress notes, visual fields, stereo disc photographs, operative reports and correspondence.

Signature: _____ Date: _____

Please mail or fax to: University Eye Specialists
676 N. St. Clair #1500
Chicago, IL 60611
P: (312)475-1000
F: (312)475-1006