BOSTON FOUNDATION *for* SIGHT

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO PROSE PARTNER CLINICS

Please note: PROSE partner clinics are independent of Boston Foundation for Sight. Fees, policies, procedures and financial assistance programs vary from clinic to clinic.

I, ____

(Name)

____

(Address)

____

(City) (State) (Zip)

Date of Birth: ______/_______/_____________

Request that a copy of my Boston Foundation for Sight records be sent to:

____

(Name of Practice)

____

(Address)

____

(City) (State) (Zip)

Phone: (_____) _______ - ____________ Fax: (______) _______ - _______________

____ __________________

Signature Date

For Office Use Only

____ OD/MD

BFS doctor authorizing transfer

____ __________________

Signature of Doctor Date

Date Sent: _______________________

By Whom: _______________________

Dates Sent: ________________________ to ____________________________

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