Stone Oak Ophthalmology Center
Lifelong Comprehensive Eye Care

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize **Kristin Story Held, M.D.** to disclose my complete ophthalmic records including visual fields and fluorescein angiography (if performed) to:

_____

_____

_____

In furtherance of this authorization, I do hereby waive all provision of law and privileges relating to the disclosures hereby authorized.

Dated this _____ day of _____, 20_____.

_____
Patient's name (please print)

_____
Patient's Date of Birth

_____
Patient's signature (or responsible party)