GENTILE RETINA

WORLD CLASS VISION & EYE CARE

Authorization for Release of Medical Information

Date: _____

To: _____

Patient Information:

Name: _____

Address: _____

Phone Number: _____

Date of Birth: _____

I hereby authorize you to release my full medical record to:

Ronald C. Gentile M.D
218 Second Ave Suite 402 South
New York, NY 10003

Patient Signature: _____ Date: _____