Authorization for Release of Records

Patient's Full Name:_____ DOB:_____

I authorize:_____

Address:_____

Phone #:_____ Fax #:_____

To release information in my medical record to:

☐ Amanda N. Hale, O.D.
457 Dalton Avenue
Pittsfield, MA 01201
Phone: 413-442-9421
Fax: 413-443-3115

☐ _____
_____
_____
_____

Please release:

____ All Records ____ Last Office Visit Other:_____

Reason for disclosure: ____ Continued Care ___Personal Records ____ Moving

Signature:_____ Date:_____

Relationship to patient:_____
(ie: Parent of minor child, Power of Attorney)