RELEASE OF RECORDS

_____ FROM: _____

PATIENT'S NAME

_____ _____

PATIENT'S ADDRESS

_____ _____

To whom it may concern:

I, _____, authorize the release of any medical records, data or information including visual fields, etc. regarding the above named patient.

Please release medical information to the following address:

Robert P. Bittel Jr., O.D. F.A.A.O.
Caste Village Shoppes
5301 Grove Road, Suite B530
Pittsburgh, PA 15236-1588

_____ _____

PRINT NAME OF PATIENT SIGNATURE (PATIENT, PARENT OR GUARDIAN)

_____ _____

DATE WITNESS