IOANNIS P. GLAVAS, MD, PLLC - 5 CAMBRIDGE CENTER, 8th FL, CAMBRIDGE, MA 02142 - (617) 725-1921 FAX: (866)365-1847

[redacted]

Request for Medical Records

IOANNIS P. GLAVAS, MD
OCULOPLASTIC
ORBITAL
LACRIMAL SURGERY

Name: _____
first middle last

Date: _____

To: _____
Doctor or Hospital to release information

_____
Street

_____
City State Zip Code

I hereby authorize and request that my medical record be released to:

Dr. _____ (recipient of information)

5 CAMBRIDGE CENTER, 8th FL
8th FLOOR, (M.E.R.S.I.)
CAMBRIDGE, MA 02142
ATTN: Medical Records

☐ To save time, please fax my record to:

(866) 365-1847

Please release information **pertaining to my ocular health**, including examination, diagnosis and treatment rendered to me by your office. Please forward records no later than _____.
(date of appt)

_____ _____
Patient's Name (Please Print) Date of Birth

_____
Street

_____
City State Zip Code

I am aware that I may revoke this authorization in writing, prior to information being released. I acknowledge that information released per this request is subject to re-disclosure by IOANNIS P. GLAVAS,MD, and may no longer be protected under HIPAA rules

_____
Patient's Signature (or Authorized Representative) Date

☐ I am an personal representative for the above named patient, and have the authority to act on behalf of this individual.

_____ _____
Witness' Signature Date Relationship to Patient