Ralph S. Viola, MD
1157 Fairport Road, Suite 201
Fairport, NY 14450
(O) 585-586-9900 (F) 585-586-7700

Authorization for the Release of Health Information to Dr. Viola

Patient Name _____ Date of Birth_____

Authorization: I, _____ , hereby authorize

(Name of Person or Organization) _____

Address _____

_____

_____

Please release medical records including office notes, tests, photos and any document which pertains to my continuing care. Excluding:

_____

To:

Ralph S. Viola, MD
Eyes on Rochester
1157 Fairport Road, Suite 201
Fairport, NY 14450

I am aware that the information regarding my medical condition will be released to those named above. This consent will expire in one year from date signed.

_____ _____
Signature Date

_____
Relationship to patient (if not signed by patient)