Fairfield Ophthalmology, LLC, Scott Seo, M.D., Ph.D.
(203) 254-8050, Fax **(203) 254-8051**

Medical Records Release

Patient: _____ _____ Date of Birth: _____
First name Last name

Authorizes: (1) (2) (circle one)
Release of Records to: (1) (2) (circle one)

(1)_____
(Name of Physician)

_____
(Name of Health Care Facility)

_____
(Street Address)

_____
(City, State, ZIP Code)

(2) Scott Seo, M.D., Ph.D.
Fairfield Ophthalmology, LLC

1300 Post Road, Suite 209
Fairfield, CT 06824

Information to be Released:
□All Clinic Records
□Last few visits only
□Other _____
□Photographs
□Visual Fields
□For the Following Dates: _____

Purpose or need for disclosure: (check applicable categories)
□Further Medical Care
□Application for insurance
□Disability determination
□Payment of insurance claim
□Vocational rehabilitation evaluation
□Legal investigation
□Personal
□Other:_____

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records.

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Signature of Patient _____ Date _____

(If signed by person other than patient, state relationship and authorization to do so)

Authorized Signature _____ Relationship _____

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Legal Authority: ☐ Legal ☐ Legal guardian ☐ Next of kin of deceased