



# ALBANY-TROY CATARACT & LASER ASSOCIATES

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## RECORDS RELEASE CONSENT

Date: \_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO ALBANY-TROY CATARACT AND LASER ASSOCIATES ANY AND ALL INFORMATION CONCERNING THE CASE HISTORY OF, AND ANY AND ALL EXAMINATIONS, TREATMENTS, AND/OR HOSPITALIZATIONS (INCLUDING CONTACT LENS RECORDS) IN THE CASE OF:

\_\_\_\_\_  
Patient's Name:

\_\_\_\_\_  
Date of Birth:

THANK YOU.

\_\_\_\_\_  
Signature of patient (parent or guardian for child)

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship

PLEASE MAIL ALL RECORDS TO:

Albany-Troy Cataract and Laser Associates  
2222 Sixth Avenue  
Troy, NY 12180

PHONE 518-274-3123  
FAX: 518-274-0624

2222 Sixth Avenue, Troy, New York 12180 • 518.274.3123 • 518.274.0624 Fax  
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