Authorization to Release Medical Records

Please send the following upon receipt:

🗁Complete Record

🗁Last visit

🗁Eyeglass prescription

🗁Retinal Photo images

🗁Contact Lens prescription

🗁Vision Therapy records

🗁Results of Consultation / Work-up

🗁Glaucoma testing images

For (patient's name)____ DOB: ______________

Address: ____

I (parent or patient >18 yo)____, authorize

Dr. or Facility name ____

to release the above records to

To: NYC Pupil – Dr. Ilana Gelfond- Polnariev P – 718-481-2020

4300 Hylan Blvd, Ste 1BC F – 347-824-2010

Staten Island, NY 10312 Email – info@nycpupil.com

Or (list where NYC Pupil to release your records to:____

____ ____________________

Signature Date