Records Release Authorization

To: ________________________________

Address: ________________________________

City/ST/Zip: ________________________________

I hereby Authorize and Request You to Release to:

Robert M. Scharf, M.D.
1645 Dorchester Drive
Plano, Texas 75075
(972) 596-3328
FAX (972) 476-1237

All of my medical records concerning my ophthalmic treatment during the period that I was under your care. Please include:

- ❏ Contact lens specifications
- ❏ Photocopies of visual fields
- ❏ Fundus photographs
- ❏ ______________________

Name: ________________________ Date: __________

Address: ________________________________

Signature: ________________________________

Witness: ________________________________