Focused Eye Care

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Drs. Helfman, Lasky & Associates
505 West Hollis St. Suite 109
Nashua, NH 03062
Phone (603) 882-0311
Fax (603) 882-3020

Authorization for Release of Medication List
For the purpose of continuity of care

Primary Care Doctor: _____

Address: _____

_____

Fax Number: _____

Patient Name: _____ **Date of Birth:** _____

Address: _____

_____

Phone Number: _____

The specific information I am requesting is most updated *MEDICATION* list.

This information should be released to :

Focused Eye Care
Drs. Helfman, Lasky & Associates
505 West Hollis St. Suite 109
Nashua, NH 03062
Phone (603) 882-0311
Fax (603) 882-3020

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date that it is signed.

Signature: _____ **Date:** _____

(Parent or Legal Guardian if a Minor)