Dr. Nancy Prybylo, OD
Eyes Rite LTD
821 Garfield St• Oak Park, IL • 60304
Phone 708-386-1554 • Fax 708-386-3413
www.eyesriteltd.com

Authorization for release of identifying health information

Patient Name: ____

DOB: ____________________ PHONE: ____________________________

Address: ____

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I authorize release of my complete medical record from: ________________

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To **Nancy Prybylo, OD** Location:Eyes Rite Ltd., (address/fax listed above)

Details of request: ____

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I have read and understand this form, and am signing voluntarily:

__________________________________ (Signature) __________ (Date)

If patient is under 18, signature of Guardian:

__________________________________ (Signature) __________ (Date)