



Records Release Authorization

To: _____
Doctors's Name

Address

I hereby Authorize and Request You to Release To:

Omar F. Almallah, M.D.
Kenneth Ehrlich, O.D.
Christopher D'Alterio, O.D.
Laura K. Sloan, O.D.

Thomas C. Pidduck, M.D.
Catherine Felicia, O.D.
Bernard Susskind, M.D.
Erik Mohaber, O.D.
Frank DeRienzo, O.D.

Check
one

The following specific information: _____

The Complete History Records in Your Possession, Concerning My Eye Condition Including Visual Field Tests, Disc or Fundus Photos, IVF results, and all Operative Reports if Applicable.

Patient's Name _____ Date: _____

Address _____

Signature _____

Send Records To: **Susskind & Almallah Eye Associates** at;

Marlboro

Philip Plaza
74 Route 9 North
Englishtown, NJ 07726

Toms River

Focus Center
20 Mule Road
Toms River, NJ 08755

Brick

Leoniak Plaza Suite 7
909 Cedar Bridge Ave
Brick, NJ 08723

Whiting

Crestwood Shpg. Ctr.
Suite 19-A
Whiting, NJ 08759

Barnegat

Victorian Plaza
890 West Bay Ave.
Barnegat, NJ 08005