Medical Records Release Form –Michael Kazim, M.D., P.C.

Patient Name: _____

To whom it may concern:

The above named patient was examined in ophthalmologic consultation.

Please be so kinds as to forward to:

Michael Kazim, M.D. 635
West 165th Street, New York,
NY 10032
or fax number is 212-923-0075
(our telephone number is 212-305-5477 if you have any questions)

The following items that have been checked:

COPIES OF OPERATIVE REPORT _____

COPIES OF PATHOLOGY REPORT _____

X-RAY FILMS _CT _Orbit & Head_____
(These will be returned posthaste)

OTHER: Eye Clinic Records_____

Thank you for your assistance in this matter
Michael Kazim, M.D.

MK/pk

I hereby authorize the release of the above requested material as indicated above.

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