



SPRINGFIELD EYE ASSOCIATES, INC.

3640 MAIN STREET • SUITE 205 • SPRINGFIELD, MASSACHUSETTS 01107-1145 • TEL. (413) 739-7367 • FAX (413) 737-2686

SARAH A. HANSON, M.D.
PHILIP MORAITIS, M.D.
BRIAN K. BREDVIK, M.D.
MATTHEW C. KIDD, O.D.

REQUEST & AUTHORIZATION TO RELEASE MEDICAL RECORDS TO **SPRINGFIELD EYE ASSOCIATES, INC.**

Please check one box only:

- ☐ Please release all information concerning my medical records, including any “sensitive” or “privileged” information.
- ☐ Please release all information concerning my medical records, except any “sensitive” or “privileged” information, specifically _____.

The above checked information is to be submitted for my care from (dates) _____
to (dates) _____.

Send to person / organization listed below:

Person / Organization: Springfield Eye Associates, Inc.

Address: 3640 Main Street, Suite 205

City: Springfield State: MA Zip Code: 01107 Fax : 413-737-2686

RECORDS REQUESTED FROM (Office):

Office / Practice: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Patient Name: _____ Date of Birth: _____

Reason for Release: _____

Signed: _____ Date: _____
Patient / Parent / Guardian (please circle one)

Witnessed: _____ Date: _____

PLEASE NOTE: This authorization is valid for this request only and it must be accomplished within 30 (thirty) days from the date the signed and completed authorization is received. Any request to revoke this authorization must be in person or in writing to protect your interests from interference.