NEWMAN TAUB & CHU
EYE CENTER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize: Newman Taub & Chu Eye Center
Dr. Gordon H. Newman, M.D.
Dr. Larry R. Taub, M.D.
Dr. Claire Y. Chu, M.D.

5744 LBJ Freeway, Suite 150
Dallas, TX. 75240
972-392-2020 fax 972-392-4054

1708 Coit Rd., Ste 240
Plano Tx, 75075
972-312-9312 fax 972-312-9369

To release full details of the medical care and treatment of:

Patient name: _____

S.S. # _____

D.O.B._____

TO:

Name of Doctor/Facility_____

Address _____

_____

_____

Phone: _____ Fax: _____

(I authorize a facsimile of this form/signature in lieu of original)

Patient Signature _____Date_____

Faxed forms must be accompanied by a Picture ID with a signature.