Physicians Eye Care & Laser Center
Patient Records Release

Patient Name:_______________________________________
(please print)

Date of Birth:________________ Day/cell phone:____________

Check one:

☐ I would like to pick up my medical records

☐ Please send my medical records to:

☐ Please obtain my medical records from:

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I am a patient of Dr. _________________________________

1001 Pine Heights Ave
Baltimore, MD 21229
Phone 410-644-9515
Fax 410-644-8250

11055 Little Patuxent Parkway
Columbia, MD 21044
Phone 410-964-8285
Fax 410-964-9414

10132-D Balt .Nat'l Pike
Ellicott City, MD 21042
Phone 410-480-9966
Fax 410-480-9985

Patient signature:

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Date:__________________

Witness:_______________________________