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:

_____

_____

_____

_____

_____

_____

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

2400 Longstone Lane
Marriottsville, MD 21104
Phone 410-480-9966
Fax 410-480-9985

Patient signature:

_____

Date:_____

Witness:_____