ROBERT
CIZIK
EYE
CLINIC

RECORD RELEASE AUTHORIZATION

TO DR:_____

I HEREBY AUTHORIZE YOU TO RELEASE TO:

Robert Cizik Eye Clinic

6400 Fannin, 18th Floor
Houston, TX 77030
TEL #: (713) 486-5200 FAX #: (713) 486-9592

THE COMPLETE MEDICAL RECORDS IN YOUR POSESSION CONCERNING MY TREATMENT DURING THE PERIORD LISTED BELOW:

FROM:_____ TO:_____

PATIENT
NAME:_____

ADDRESS:_____

_____

- **I FURTHER RELEASE AND FOREVER DISCHARGE ROBERT CIZIK EYE CLINIC AND ALL OF THE DOCTORS ASSOCIATED FROM ANY AND ALL CLAIMS, DEMANDS, DAMAGES, COSTS, AND CAUSES OF ACTION IN WHICH MAY OCCUR AS A RESULT OF THE RELEASE OF THESE RECORDS.**

SIGNATURE:_____

DATE:_____

WITNESS:_____