



Lions Orthoptic Clinic of Western Mass.  
c/o Pres. Jean W. Martin  
172 Hope St, Greenfield, MA 01301

Medical Record Release Authorization

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: \_\_\_\_\_

\_\_\_\_\_ I hereby authorize The Lions Orthoptic Clinic of Western Mass TO RELEASE the following information to:

\_\_\_\_\_ Shelley Klein Weiss, Tufts, New England Eye Center, 800 Washington Ave, Box 450, Boston, MA 02111 (her # is 617-636-6769)

\_\_\_\_\_ Other Provider: (please list name, address, telephone) \_\_\_\_\_

\_\_\_\_\_ Information to be released (cross out any category that you wish to be withheld):  
Complete medical record including mental health or psychiatric treatment, substance abuse and detoxification information; information pertaining to AIDS, HIV status or test results; information pertaining to sexually transmitted diseases.

\_\_\_\_\_ Release only the following specific information/tests: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Reason for release of information:

Transferring to another practice due to closing of the Lions Orthoptic Clinic

I release The Lions Orthoptic Clinic of Western Massachusetts from all legal responsibility and I request that this consent become invalid one year from the date listed below. I understand that I may contact the Lions Orthoptic Clinic of Western Massachusetts, or its assigns, to withdraw this permission.

Signature of Patient/Legal Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_