Authorization to Release Medical Records

Please send the following upon receipt:

- 🗁 Complete Record
- 🗁 Last visit
- 🗁 Eyeglass prescription
- 🗁 Retinal Photo images
- 🗁 Contact Lens prescription
- 🗁 Vision Therapy records
- 🗁 Results of Consultation / Work-up
- 🗁 Glaucoma testing images

For (patient's name): _____ DOB: _____

Address: _____

I (parent or patient >18 yo)_____, authorize

Dr. or Facility name_____
to release the above records

To: NYC Pupil – Dr. Ilana Gelfond- Polnariev
4079 Richmond Avenue
Staten Island, NY 10312

P – 718-481-2020
F – 347-824-2010
Email – info@nycpupil.com

Or (list where NYC Pupil to release your records to: _____

_____ _____
Signature Date

NYC Pupil