DIANE HILAL-CAMPO, M.D.
OPHTHALMOLOGY

43 YAWPO AVENUE, SUITE #1
OAKLAND, NEW JERSEY 07436
OFFICE: (201) 337-9300
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Release of Medical Records Consent

Social Security #_______________________________ Date of Birth _________________

Last Name ________________________ First Name______________________ M.I. ____

Physician's Last Name Hilal-Campo First Name Diane

Specialty: Ophthalmology

Address 43 Yawpo Ave., Suite #1

City Oakland State N.J. Zip Code 07436

Phone # (201) 337 - 9300 Fax # (201) 405 - 0558

Physician's Name / Group Name ____

Address ____

City ____________________________ State ___________ Zip Code __________________

Phone # ____________________________ Fax# _________________________________

I authorize the release of my medical records to Dr. Diane Hilal-Campo from the Physician, and / or group that is named above. I release the above-named Physician, and / or group from all legal responsibility that may arise from this authorization.

_______________________________________ ___________________________________

Signature of Patient Date