

DR. DIANE HILAL-CAMPO, M.D.
DR. ERIC M. SAUNDERS, MD
OPHTHALMOLOGY

43 YAWPO AVENUE, SUITE #1
OAKLAND, NEW JERSEY 07436
OFFICE: (201) 337-9300
FAX: (201) 405-0558

**Release of Medical Records Consent TO DR. DIANE HILAL-CAMPO /
DR. ERIC M. SAUNDERS**

Social Security # _____ Date of Birth _____

Last Name _____ First Name _____ M.I. _____

Physician's Last Name Diane Hilal Campo, MD or Eric Saunders, MD

Specialty: Ophthalmology

Address 43 Yawpo Ave., Suite #1

City Oakland State N.J. Zip Code 07436

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

PREVIOUS EYE DR _____

Address _____

City _____ State _____ Zip Code _____

Phone # _____ Fax# _____

I authorize the release of my medical records **TO** Dr. Diane Hilal-Campo / Dr. Eric M. Saunders **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

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DR. ERIC M. SAUNDERS, MD
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EYE DR / RECIPIENT _____

Address _____

City _____ State _____ Zip Code _____

Phone # _____ Fax# _____

I authorize the release of my medical records **FROM** Dr. Diane Hilal-Campo / Dr. Eric M. Saunders **TO** 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. **I understand there is a fee of \$10.**

Signature of Patient

Date