Pediatric Eye Associates
Deborah R. Fishman, M.D.
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Main Office:
3612 Lake Ave., Suite 2C
Wilmette, IL 60091

PLEASE BE AWARE THAT WE DO **NOT E-MAIL RECORDS OR ANY MEDICAL INFORMATION**

DATE:_______________________

Dear Pediatric Eye Associates:

I hereby give permission to release the records of

PATIENT NAME:_______________________________

DATE OF BIRTH:___________________________

TO:
NAME OF **DOCTOR/PRACTICE** OR **PARENT/GUARDIAN**

____

ADDRESS:

____

PHONE & FAX NUMBER

____

Thank You.

____
SIGNATURE of
PARENT/GUARDIAN or PATIENT(18yrs or older)

Phone: 847-256-2020 **Fax: 847-256-2222**