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- Alina Balasa, O.D.
- Natalia Kobrenko, O.D.

## Records Release Form

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

To/From:

To/From:

Bucks-Mont Eye Associates  
711 Lawn Avenue  
Building 3  
Sellersville, PA 18960

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

Phone: 215-257-8053  
Fax: 215-257-2020

Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

I authorize the release of my medical records.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian/Relationship