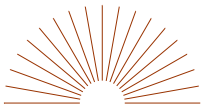

UNIVERSITY EYE SPECIALISTS

Lisa F. Rosenberg, MD
Jon M. Ruderman, MD
John Yang, MD
Gina Piper, OD

Authorization for Release of Information to UES

Name:		
Date of Birth:	**Social Security#:**	
Address:		
City:	**State:**	**Zip Code:**
Telephone #:		

I request and authorize:

Doctor:		
Address:		
City:	**State:**	**Zip Code:**
Telephone #:	**Fax #:**	

To furnish to **University Eye Specialists** all of my ophthalmology (eye) records, including progress notes, visual fields, stereo disc photographs, operative reports and correspondence.

Signature: _____

Date: _____

676 N. St. Clair Suite 1500 Chicago, Illinois 60611 312 475-1000 Fax 312 475-1006
1535 Lake Cook Road Suite 305 Northbrook, IL 60062 847 562-4330 Fax 847 562-4331