



**UNIVERSITY EYE SPECIALISTS**

LISA F. ROSENBERG, MD  
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**Authorization for Release of Information  
To University Eye Specialists**

Patient 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: \_\_\_\_\_

Please mail or fax to: University Eye Specialists  
676 N. St. Clair #1500  
Chicago, IL 60611

F: (312)475-1006