Records Transfer Request

Date: ______________________

RE: _______________________________

Date of Birth: ______________________

Address: _______________________________________

____

____

I Hereby authorize the release of my records or copies of such and request that they be transferred. Please include last and first exam and any relevant photographs, OCT, angiograms or other information.

From: _______________________________________

____

____

To: The Retina Group of New York
400 S. Oyster Bay Rd. Suite 305
Hicksville, NY 11801

____
Signature (patient, parent or guardian)

James M. Maisel, M.D., F.A.A.O. • Rodney P. Coe, M.D., M.S. • Sabah Shah, M.D., M.B.A.

400 South Oyster Bay Road, Suite 305
Hicksville, NY 11801-3516
Tel (516) 939-6100
Fax (516) 939-2510

Vitreoretinal and Laser Surgery
www.rgony.com

1455 Veterans Memorial Highway
Hauppauge, NY 11749
Tel (631) 273-1818
Fax (516) 939-2510