**Dr. Nicholas Skouras MD, FRCS, DABO**



20 Eglinton Ave. West Suite 1108

Toronto, ON M4R 1K8

Tel: 416-590-0445

Fax: 416-590-0446

[www.skouraseye.com](http://www.skouraseye.com)

**Patient Consent for Medical Release Form**

Authorization For Use or Disclosure of Patient Files.

RE:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize the use or disclosure of my health information

(name of person or organization releasing information)

to be released to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization applies to patient consultation notes, and/or tests, and/or results and is not to be disclosed without additional patient consent to anyone other than the above mentioned party.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_