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Authorization for Facsimile & E-Mail

Rosin Eyecare & Comprehensive Eyecare Physicians Fax and Email Request Authorization

I, _____ understand that you will be transmitting my medical records electronically and authorize you to do so. If another party receives my medical records in error, I absolve Dr. _____ of any and all liability to such submission of said records.

Delivery Method

Please **FAX** my medical records to ( ) _____

Please **EMAIL** my medical records to _____

Patient's Name _____ **Signature** _____

Date _____