Christina Antonopoulos, MD, FACS
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Request for Medical Records

To whom it may concern:

I hereby authorize the practice to release my existing medical information and records to *Christina Antonopoulos, MD, FACS* of the *Greater Baltimore Retina* for the continuation of my care.

Please forward my records to the office indicated below:

- ❏ 8601 LaSalle Rd, Suite 207, Towson, MD 21286. FAX: 731-201-5959
- ❏ 5 Carroll Plaza, Westminster, MD 21157, FAX: 731-201-5959

Date(s) of service:

_____

I understand that this authorization is valid for one (1) year or revoked through written notice to the Medical Records department of the practice.

Signature of patient: _____

Printed name: _____

Date of Birth:_____

Date: _____