

**Robert H. Brown, M.D.**  
**R. Stephen Brown, M.D.**  
**Christopher D. Brown, M.D.**  
**Andrew C. Brown, M.D.**  
*Ophthalmology & Ophthalmic Surgery*  
751 Teaneck Road  
Teaneck, NJ 07666  
201-833-0006  
Fax: 201-833-9238

## **Consent For Release of Medical Records**

I, \_\_\_\_\_, request that Dr. \_\_\_\_\_ send a copy of my medical records to Dr. Brown at the above address.

**Date** \_\_\_\_\_ **Patient's Signature** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Social Security No.** \_\_\_\_\_