BUCCI CATARACT AND LASER VISION INSTITUTE
158 Wilkes-Barre Township Boulevard
Suite 201
Wilkes-Barre, PA 18702

Phone: (570) 825-5949 Toll Free: (877) SEE-2015 Fax: (570) 825-2645

# CONSENT TO RELEASE PATIENT RECORD

I,_____, hereby authorize _____

to release records obtained in the course of my diagnosis and treatment to:

**BUCCI CATARACT AND LASER VISION INSTITUTE**
**158 WILKES-BARRE TOWNSHIP BOULEVARD**
**SUITE 201**
**WILKES-BARRE, PA 18702**

_____ _____
[Patient Signature] [Date]

_____
Parent [If Patient is a minor]

_____
[Witness]