Dr. Rosanna C. LaMalva
10 City Hall Avenue
Boston, MA 02108
Phone: 617-523-9700

RECORD RELEASE FORM

I, _____, authorize the office of Dr. Rosanna C. LaMalva to release a copy of my eye examination records to _____.
(Please Circle One) Please leave for me to pick up / Please mail to the following address:
_____.
(City) (State) (Zip Code) (Phone Number)

I understand this is a photocopy only of my eye examination records and that the original records remain in the possession of Dr. Rosanna C. LaMalva. I also understand that this photocopy is not intended and can not be used to fill any expired eye glasses, contact lens or drug prescription.

Sincerely,

_____ _____ _____
(Patient's Signature) (Patient's Name, **please print**) (Today's Date)