San Carlos EYE CARE

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**Ninh H. Tran, M.D.**
**Alan L. Susal, M.D.**
**Richard B. Braunstein, M.D.**
**Nary Chum, O.D.**

Patient's Name: _____

Date of Birth: _____ Phone:_____

I hereby authorize _____

to release a copy of my health information to:

☐ San Carlos Eye Care.

☐ _____

Description of information to be released: (check all that apply)

☐ Entire medical record

☐ Immunization record
☐ Laboratory reports
☐ Radiology/Imaging reports
☐ Radiology films
☐ Most recent history and physical
☐ Consultations
☐ Progress notes
☐ Other_____

Time period these records cover

☐ All
☐ From _____ To _____

_____ _____
Signature of Patient *or* Patient's Representative Date

_____
Printed Name of Patient *or* Patient's Representative