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RECORD RELEASE

PATIENT'S NAME: ______________________________________ **DOB:** ________________________

ATTENTION TO:

Melanie Hom, MD • Cynthia Chiu, MD, FACS • Jennifer De Niro, MD • Shin Lee, OD

491 30th Street, Suite 201
Oakland, CA 94609

I hearby authorize you to release records to: ____

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Any information regarding the diagnosis and medical records of any examination, treatment, Visual fields, OCT, and Fundus Photos rendered to me for the period of:

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Print name: __________________________________

Signature: ____________________________________ **Date:** __________________________________