RECORD RELEASE / REQUEST

TO:

ADDRESS:

PHONE #:

FAX #:

I hereby authorize my optometrist/ medical records to be released and transferred to/ from:

OPTIMA OPTOMETRY
HELENA H.P. NGUYEN, O.D.
3480 EL CAMINO REAL
SANTA CLARA, CA. 95051
Phone #: (408) 247-5102
Fax #: (408) 247-5946

NAME OF PATIENT:

BIRTHDAY:

SOCIAL SECURITY NUMBER:

PATIENT'S SIGNATURE:

DATE: