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AUTHORIZATION TO RELEASE/OBTAIN PATIENT MEDICAL INFORMATION

I hereby authorize the office of Pamela Fong, O.D. and Sandra Miyamoto, O.D. to release/obtain my medical information.

Obtain From:

Name: _____

Address: _____

_____

Tel: _____

Fax: _____

Release To:

Name: _____

Address: _____

_____

Tel: _____

Fax: _____

Comments: _____

_____

_____

Patient Name: _____

Patient Address: _____

_____

Patient Tel: _____ Patient DOB: _____

Patient Signature: _____ Date: _____