Dr. B.N. Le
Optometric Glaucoma Specialist
"The Health of Your Eyes Starts Here"

MEDICAL RECORD RELEASE

Date: _____

Patient's Name: _____DOB:_____
agrees and authorizes

☐ for all my medical record to be released from

☐ Dr. _____At _____

Phone #_____Fax #:_____

☐ EyeRis Vision Center to release my medical records to

☐ Dr. _____At _____

Phone #_____Fax #:_____

☐ to have this person, named below, to have access to my medical records

Name_____Relationship to patient:_____

Please check proffered medical release method

☐Phone ☐Mailing: Address _____

☐Email:_____ _____

Notes:_____

Patient/Guardian's Authorization Signature: _____

If guardian, Print Name:_____

EyeRis's staff: _____Signature:_____

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