



Sandra Cheng, OD
Michael J. Drinnan, MD
Sharon Ho, OD
Thomas G. Neumayr, MD

Donna Ornitz, MD
Beverly L. Sarver, MD
Medhi Vahdat

AUTHORIZATION TO RELEASE/OBTAIN PATIENT MEDICAL INFORMATION

I hereby authorize Peninsula Eye Physicians to release/obtain my medical information as listed:

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone _____

OBTAIN FROM:

RELEASE TO:

NAME

NAME

ADDRESS

ADDRESS

CITY,STATE,ZIP

CITY,STATE,ZIP

INFORMATION REQUESTED

SPECIFIED DATES

- Entire medical record
Lab results
x-ray results
Last exam
Other

From: _____
To: _____

Information Protected by State/Federal Law

- Drug abuse diagnosis/treatment
Alcoholism diagnosis/treatment
Mental Health diagnosis/treatment
Sexually transmitted disease diagnosis
Treatment or counseling(AIDS/HIV)

NOTE: THERE IS A \$10.00 FEE FOR COPYING MEDICAL RECORDS.

I UNDERSTAND THAT THIS AUTHORIZATION IS VALID FOR 90 DAYS AND MAY BE REVOKED IN WRITING AT ANY TIME PRIOR TO 14 DAYS BY NOTIFYING MEDICAL RECORDS.

Signature of Patient or legally responsible party

Date of Request

Date received Initials