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AARON KWAN, O.D.
MEGAN TAI, O.D.

Authorization to Release / Obtain Patient Medical Information

Please note: There is a $20:00 fee for copying medical records up to 10 pages.

After 10 pages, the fee will be $35:00 for all records on a USB drive.

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

Patient Name: ____ DOB: _______________________

Address: _________________________________ City________________________ State________ Zip__________________

Phone Number: ____________________________________

OBTAIN FROM:

____
NAME

____
ADDRESS

____
CITY, STATE, ZIP

____
PHONE / FAX

RELEASE TO:

____
NAME

____
ADDRESS

____
CITY, STATE, ZIP

____
PHONE / FAX

Information Requested:

____ Entire EYE Record
____ Lab Results
____ X-Ray Results
____ Last Exam
____ Other______________________________

Specified Dates:

From :_______________________

To:_________________________

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

____
Date records mailed / e-faxed

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