Advanced Vision Care

Eye Physicians and Surgeons

Nicole Fram, M.D. Sahar Bedrood, M.D.
Ayaka Sato, O.D. Juliana Nghiem, O.D. Melody Kordnaij, O.D.

Records Release Form

Date Requested: _____ Patient Name: _____

Patient Date of Birth: _____

I hereby authorize my medical records to be released.

Records Released From:	Records Released To:
_____	_____
Doctor or Hospital	Doctor, Hospital, or Patient (Self)
_____	_____
Address	Address
_____	_____
City/State/Zip	City/State/Zip
_____	_____
Phone Fax	Phone Fax

THIS AUTHORIZATION SHALL BECOME EFFECTIVE IMMEDIATELY AND SHALL REMAIN IN EFFECT UNITL _____ OR FOR ONE YEAR FROM THE DATE OF SIGNATURE IF NO DATE IS ENTERED.

This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. I understand that the requester may not lawfully further use or disclose the health information unless another authorization from me.

_____ _____
Signature of Patient or Guardian Date Signed

_____ _____
Witness Date Signed

2080 Century Park East, Suite 911, Los Angeles, CA 90067 Phone 310 229 1220 Fax 310 229 1222
www.advancedvisioncare.com