Advanced Eye Health & Surgical Care
554 E. San Bernardino Road, Ste. 102
Covina, CA 91723
626-332-1888
626-332-1808
www.omnieyecare.com

MEDICAL RECORD RELEASE FORM

Telephone: 626/332-1888 (Voice Mail)
Fax: 626/332-1808
E-mail: info@omnieyecare.com

________________________________ ____________________
Patient Name Date of Birth

I hereby authorize the below listed entity to release medical information to Omni Eye Care, Inc.:

Name: ______________________________ Telephone#: __________
Address: _____________________________ Fax#: ______________
____

Medical Information Requested:

- ☐ All Records
- ☐ Prescription Records, Glasses and Contacts
- ☐ Specific Records from ______________ to _______________
- ☐ Physical Examinations
- ☐ Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.}

___________________________________ __________________
Signature of Patient or Legal Guardian Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.