AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TODAY'S DATE: _____

PATIENT NAME: (Last, First) _____

Date of Birth: _____

I here by authorize, my **previous** eye care doctor:

_____

Phone Number: _____ Fax Number:_____

To release information from my records to:

☐ **Nova Eyecare Center**
Dr. Nhan T. Tran, OD
450 E. Tudor Road, Suite 200
Anchorage, AK 99503
Tel: 907.274.7825 Fax: 907.274.7826
Email us: *info@novaeyecares.com*

Specific information I wish to have released is:

____ Glasses & Contact Lens Prescriptions

____ Eye Exam Records

Signature: _____ Date: _____
(Parent or legal guardian if minor)