

# Advanced Eyecare of Orange County

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## AUTHORIZATION FOR MEDICAL RECORDS RELEASE

PATIENT NAME: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Treatment Dates: \_\_\_\_\_

### Information To Be Released From:

Physician/Medical Group: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City/State: \_\_\_\_\_ ZIP \_\_\_\_\_

### Information To Be Released:

<input type="checkbox"/> Hospital Reports	<input type="checkbox"/> Lab/X-Ray Reports	<input type="checkbox"/> Pachymetry
<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> Medication Records	<input type="checkbox"/> Surgical Reports
<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Consultation Reports	
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Visual Fields	
<input type="checkbox"/> ALL MEDICAL RECORDS		

Other(specify): \_\_\_\_\_

This authorization is effective immediately and is subject to revocation at any time, except that action has already been taken. Otherwise, the authorization expires 90 days from the date of signing.

I understand that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released, and that I may refuse to sign.

In addition to the above records, I consent to the release of records including those of:

Drug/Alcohol/Substance Abuse	_____ (initial)
Psychiatric/Mental Health	_____ (initial)
Tests for Antibodies to HIV	_____ (initial)
AIDS diagnosis	_____ (initial)

I further release my attending physician, consultants, the facility and employees from any liability arising from the release of information to the person(s)/agency designated above.

I understand that I have the right to receive a copy of this authorization upon my request.

Signature of PATIENT \_\_\_\_\_ DATE \_\_\_\_\_

Signature of Guardian \_\_\_\_\_ DATE \_\_\_\_\_

Relationship to Patient \_\_\_\_\_