



Dr. (Jan) Trang Dao, OD
Dr. Huy Tran, OD
Dr. Clara Le, OD
Dr. Van Nguyen, OD

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize

Fax: _____

to provide all current and up to date records pertaining to my vision history, services rendered, or treatment given to:

InFocus Vision
305 W. FM 1382 Suite #524B
Cedar Hill, TX 75104

You are further authorized to communicate with _____ either orally or in writing regarding the requested information.

DATE: _____ **PATIENT'S NAME:** _____

PATIENT'S SIGNATURE: _____
(or guardian if under 18)

PATIENT'S DATE OF BIRTH: _____