INFORMATION RELEASE FORM

To release the patient records from:

VISION EYE GALLERY
Dr. Pauline Nguyen, O.D. & Associates, P.A.
11602 Lake Underhill Rd, Suite 103
Orlando FL 32825
Office #: (407) 381-7001
Fax #: (407) 381-7004

TO:

Patient Name: _____ Date of Birth: _____

_____
(Street Address)

_____ (___)_____ (____)_____
(City, State, & Zip Code) Phone No. Fax No.

Date: _____ Chart Number: _____

I authorize: _____
(Physician or Institute)

This information is CONFIDENTIAL. Re-disclosure of this information is strictly prohibited by law without the written permission of the person to whom it pertains.

I, the undersigned, hereby release the above mentioned institution from any liability which may arise from release and/or examination of the information indicated above. I understand that there may be a charge for copies and record review and those charges must be paid prior to review or release of copies.

Signed: _____ Date: _____