INFORMATION RELEASE FORM

Patient Name: ____ Date of Birth: ________________

Date: _______________ Chart Number: _________________

I authorize: ____
(Physician or Institute)

____
(Street Address)

____
(City, State, & Zip Code)

To release the above records to:

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

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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: ______________