optometry parkside

1880 S. Norfolk St • San Mateo, CA 94403 • (Phone and Fax) 650-830-5675 • email: ParksideODS@Gmail.com

Date: _____

RE: Release of medical records for: _____

DOB: _____

Dear Parkside Optometry:

I am authorizing and requesting that you release all medical records pertaining to the above named patient. This information should be sent to:

Name: _____

Address: _____

_____

Fax: _____

Email: _____

Sincerely,

Name: _____

Relation to Patient: _____ Patient _____ Guardian/Parent