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

To: _____

_____

_____

Date: _____

Dear _____:

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

Parkside Optometry
1880 S. Norfolk St
San Mateo, CA 94403
Fax: 650-830-5675
Email: ParksideODs@Gmail.com

Release of medical records for: _____

DOB: _____

Sincerely,

Name:_____
Relation to Patient: _____ Patient _____ Guardian/Parent