**Dr. Bich Nhat (B.N.) Le**
Optometric Glaucoma Specialist
*"The Health of Your Eyes Starts Here"*
www.eyerisvision.com

## MEDICAL RECORD RELEASE

I _____, DOB _____ agrees and authorizes the following (check any/all that applies).

1. ☐ for all my medical record to be released from

   Dr. _____At _____

   Phone #_____Fax #:_____

2. ☐ for EyeRis Vision to release my medical records to

   Dr. _____At _____

   Phone #_____Fax #:_____

3. ☐ to have this person, named below, to have access to my medical records

   Name_____

   Relationship_____

   Phone #_____Fax #:_____

Please send my medical records to:

☐Southpark Meadows location. 9900 S. IH 35, suite J-34. Austin, TX 78748. P: 512.292.9326. F: 512.645.2995. Email: info@eyerisvision.com

☐So-La location. 3111 South Lamar Blvd. Austin, TX 78704. P: 512.222.5636. F: 512.580.9957. Email: eyerisvision.atx@gmail.com

Additional notes:_____

Patient/Guardian's Authorization Signature: _____

If guardian, Print Name:_____Date_____

EyeRis's staff: _____Signature:_____