Dr. (Jan) Trang Dao, OD
Dr. Karen Nguyen, OD
Therapeutic Optometrist

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ____, hereby authorize

____

____

____

Fax: ____

to provide all current and up to date records pertaining to my vision history, services rendered, or treatment given to:

InFocus Vision
4800 S. Hulen St. #2720
Fort Worth, TX 76132

You are further authorized to communicate with _________________________ either orally or in writing regarding the requested information.

DATE: ________________________ **PATIENT'S NAME:** ____

PATIENT'S SIGNATURE: _____________________________________
(or guardian if under 18)

PATIENT'S DATE OF BIRTH: __________________________________

4800 S. Hulen St. #2720
Fort Worth, TX 76132
www.infocusvisiontx.com

Office (817) 346-2186
Fax (817) 370-7902
infocusvisionstaff@gmail.com