Dr. Wynn N. Tran
Integrative Optometry & Vision Rehab/Therapy

RELEASE OF RECORDS

To: Provider _____

Phone (_____) _____

Fax (_____) _____

RE: PATIENT : _____ **DOB :**_____

Dear Provider,

The patient above has an appointment for an eye exam. Please send patient records to our office by mail or secure **FAX (510) 853-7047** at your earliest convenience.

Please include all ancillary testing such as visual fields, imaging, and photos, if sent from optometry/ophthalmology offices to aid in the patient's comprehensive care.

Thank you,

Wynn N. Tran, OD, FAAO, FCOVD
Heal My Eyes Optometry

Patient Authorization:

I authorize the above named provider to release this information.

Signature: _____ Date : _____

45 San Clemente Dr, Suite B130
Corte Madera, CA 94925
Office: 415-927-1211

1844 San Miguel Dr, Suite 300C
Walnut Creek, CA 94925
Office : 888-551-9991