



Dr. Wynn N. Tran

Integrative Optometry & Vision Rehab/Therapy

RELEASE OF RECORDS

To: Provider \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

Fax (\_\_\_\_\_) \_\_\_\_\_

<b>RE:</b>	<b>PATIENT :</b> _____	<b>DOB :</b> _____
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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 : \_\_\_\_\_

The information contained in this facsimile message is privilege and confidential information intended for the use of the addressee listed above. Unauthorized disclosure of the content of this telecopied information is strictly prohibited. If you received this facsimile in error, please notify us immediately.

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