Harvey H. Yamamoto, O.D., Inc.

417 N EUCLID AVENUE ♦ ONTARIO, CA 91762 ♦ (909) 986-9951

Harvey H. Yamamoto, O.D. Sean H. Yamamoto, O.D. Beverly A. Nishitani. O.D.

AUTHORIZATION FOR RELEASE OF INOFRMATION FROM THE MEDICAL RECORD

Patient's Name: ____ Date of Birth: __________________

I, the undersigned, authorize Harvey H. Yamamoto, O.D., INC. to provide:

____
Name

____
Address

____
City State Zip

____
Phone #

____
Fax #

____
Email to provide access to records

Access to my medical records for the purpose of: ____

The authorization is subject to the following limitations:

Confined to records regarding treatment for the period from _____________ to _____________

This consent is subject to revocation by the undersigned at anytime except to the extent that action has been taken in reliance thereon, and if not earlier revoked, it shall terminate 3 months from the date of consent without express revocation.

Please note if you want us to send or mail the records in paper format there will be additional charges.

____ _________________________
Patient/Guardian Signature Date

____ _________________________
Witness Signature Date

Any disclosure of medical record information by the recipient is prohibited except when implied in the purpose of the disclosure.

Date Consent Terminates:__________________