

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

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Harvey H. Yamamoto, O.D.

Sean H. Yamamoto, O.D.

Beverly A. Nishitani, O.D.

AUTHORIZATION FOR RELEASE OF INFORMATION 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 #

Access to my medical records for the purpose of: _____

I further authorize you to provide such copies thereof as may be requested.

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.

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: _____