Miyasaka Eye Care

Richard H. Miyasaka, O.D. ~ James K. Miyasaka, O.D.

PERMISSION TO RELEASE PATIENT RECORDS

Date: ______________________________________

To: ______________________________________

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Patient: ______________________________________

DOB: ______________________________________

I hereby grant permission to this office to release my patient records to Richard H. Miyasaka, O.D., LLC (dba Miyasaka Eye Care). The medical findings and treatment records should cover all examinations and spectacles and/or contact lens prescription information. In granting this request, I hereby release my practitioner from any laws governing the disclosure of confidential or privileged information.

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SIGNATURE OF PATIENT (parent or guardian if minor)

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