



— STANFORD RANCH —
Optometry

2351 Sunset Blvd Ste.190 Rocklin, CA 95765
Phone (916)624-9396 Fax (916)624-9215

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____

Date of Birth: _____

I authorize release of information from:

Name of Provider: _____

Phone: _____ Fax: _____

Recipient: Kristyna Lensky Sipes O.D.
Navrit Purewal O.D.
Lisa Hornick O.D., F.A.A.O.

Information to be Disclosed:

Please release a copy of ALL my medical records.

Please release my spectacle/contact lens RX.

Other: _____

Signature of Patient or Legal Representative:

_____ Date: _____

The information in this facsimile is for the exclusive and personal use of the above named recipients and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If you are not a designated recipient of this document, the agent responsible for delivering the message to the intended recipient, or if you have obtained it in error, please be advised that reading, distribution, and/or duplication of this information is expressly prohibited. If the transmission came to you by mistake, please notify us immediately by telephone or return facsimile.