—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:_____