Medical Records Release

Patient Name:
Address:
Date of Birth:
Phone number:

Records to be released to Zahra Ghiasi M.D.
Phone: 949-777-5970
Fax: 949-679-7447
Address: 113 Waterworks Way, Ste 245, Irvine CA, 92618

Records Release From:

Name_____

Address: _____

Tel: _____Fax:_____

Information to be released:

☐ Last 3 office visit notes
☐Last 3 visual fields
☐ Last 3 Optic nerve head studies (OCT/HRT/GDX)
☐ Operative reports
☐ IOL master/intra ocular lens calculation
☐ Topography
☐ Laser refractive data

I further understand that I may always revoke this release through written notice to Medical Records. I authorize the release of my medical records in accordance with the specifications listed above.

Signature of Patient_____ Date _____

If signed by person other than patient:

Patient's Status: ☐Minor ☐ Incompetent ☐ Disabled ☐ Deceased
Authority: ☐ Legal ☐ Legal Guardian ☐ Next of Kin
Relationship to Patient: