

Records Release Request

To: _____

(Doctor or Clinic)

Address: _____

City: _____

Telephone: _____

Fax: _____

I hereby authorize the release of all my medical records from:

Advanced Ophthalmology Institute

Mihir Parikh MD

4150 Regents Park Row Ste. 155

La Jolla, CA 92037

TEL: 858-450-4213

FAX: 858-450-4219

Print Name of Patient

Date of Birth

Signature of Patient, Parent or Guardian

Social Security #