

Records Release Request

From: \_\_\_\_\_  
(Doctor or Clinic)

Address: \_\_\_\_\_

City: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

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

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 #