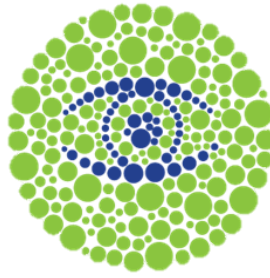


FOSTER CITY OFFICE

Jacqueline Tung O.D.  
12743 TLG, NPI 1619089323

Shiu Yuen Kwok M.D., Ph.D., J. D.

967 E. Hillsdale Blvd., Suite B1  
Foster City, CA 94404  
Ph: (650) 286 1388  
Fax: (650) 268 8645  
Email: fostercity@eyehealthopt.com



**Eye Health Optometry**

NEWARK OFFICE

Jacqueline Tung O.D.  
12743 TLG, NPI 1619089323

Wayne Halstrom O.D.  
5864, NPI 1881751501

5749 Stevenson Blvd  
Newark, CA 94560  
Ph: (510) 791-2020  
Fax: (510) 226-6445  
Email: newark@eyehealthopt.com

**RECORD RELEASE FORM**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Request Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

I \_\_\_\_\_ (patient) hereby authorize the release of my medical information, receipts of payment or balance due, and/or other information considered under the HIPAA privacy law to be part of the Designated Record Set to or from the office of Eye Health Optometry, please remit expediently.

**Medical Information Requested:**

- Prescription
- Invoiced Receipt
- Other \_\_\_\_\_

\_\_\_\_\_  
(Signature) of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Print) Patient or Legal Guardian

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, autoimmune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.