

Sunnyvale Optometry
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Date: _____

To: _____

I authorize you to release my records to:

- _____ Cindy Tran, O.D.
- _____ Spencer Lee, O.D.
- _____ Michela Fong, O.D.
- _____ _____

Patient Signature: _____

Patient Name (Print): _____

Date of Birth: _____

Approximate Date Last Seen: _____