THEM (TAMMY) LE VU, M.D.
QUANG (KEVIN) TRAN, O.D.
6300 STONEWOOD DRIVE # 304
PLANO, TEXAS 75024
PHONE: (469) 467-8100
FAX: (469) 467-4556

TRICON EYE CARE CENTER & BEST OPTICAL

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name ______________________________ **DOB** ____/____/______

First Name Last name

Address ______________________________ **Phone** _____-______-______

Street Name City State Zip Code

I authorize the release or disclosure of my personal health information between the following individuals or entities.

❖ I am requesting records from:

Name: **Tricon Eye Care Center**

Address: **6300 Stonewood Drive Suite 304 Plano, TX 75024**

Phone: **469-467-8100**

Fax: **469-467-4556**

❖ I am requesting records to be sent to:

Name: ______________________

Address: ______________________

Phone: ______________________

Fax: (_____) ______-_______

__PCP __Optometrist __Ophthalmologist
__ Other ______________________

Purpose of disclosure:

___1. Transfer of Care
___2. Coordination of Care
___3. Second Opinion

The information to be released
__ Complete Medical Records- Only For Transfer of care (Ophthalmologist) preferred :
__ Specific Exam Date _____________
__ Operative Reports
__ Complete Medical Records Not For Transfer Will Inquire A Processing Fee As Noted Below

In order to process our request for medical records, this form must be completed in its entirety. You have the right to withdraw this request at any time. Unless withdrawn, this authorization will remain valid for 90 (ninety) days from the date at the bottom of this form.

Please note that our office policy require a processing time frame of 5-7 working business days to complete your request. In addition, patients requesting records for multiple doctors or requesting records when it's not necessary for patient care) ex: for personal uses, for lawyers, for doctors not involved in the patient's eye care, etc) will incur a charge of $25 for the first 20 pages and $0.50 for each additional page.

The information being requested is privileged and confidential. It is intended for the individual or entity designated. You are hereby notified that any dissemination, distribution, copying, or other use of this information by anyone other than the recipient designated is unauthorized and strictly prohibited.

Signature of Patient or Representative ______________________ Date ____________