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 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: _____

Address:_____

Phone: (_____) _____-_____

Fax: (_____) _____-_____

❖ I am requesting records to be sent to:

Name: **Tricon Eye Center**

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

Phone: **469-467-8100**

Fax: **469-467-4556**

The information to be released

__ Diabetic Control Hgb A1C Results
__ Glaucoma Exams & Tests (VF, Nerve Scans)
__ Latest Exam Report
__ All Medical Records
__ Other _____

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 Unless withdrawn, this authorization will remain valid for 90 (ninety) days from the date at the bottom of this form.

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