

Craig J. Leong, M.D., P.C. Stewart A. Daniels, M.D., P.C. Subhransu K. Ray, M.D., Ph.D., P.C. T. Daniel Ting, M.D., Ph.D., P.C.
Tushar M. Ranchod, M.D., P.C. Roger A. Goldberg, M.D., M.B.A. Caesar K. Luo, M.D., F.A.C.S.

Consent to Release Medical Information

I _____, DOB _____, hereby authorize and request the custodian of my medical records at:

to release copies of my records containing medical history, treatment, lab records, diagnosed mental or physical condition, including disabilities such as drug, alcohol, and psychiatric or the result of any HIV test performed from the period of:

Date: _____ to _____

I understand this authorization will expire on: _____

Please mail or fax my records to: Bay Area Retina Associates

This authorization includes any and all records which are part of said medical records and which are subject to the confidentiality requirements established by Section 5328 of the California Welfare and Institutions Code and Article 7 of Chapter 4 of Division 8 of the California Evidence Code and HIPAA Federal Law.

Signed: _____

Dated: _____

Witness: _____

365 LENNON LANE, SUITE 250
WALNUT CREEK, CA 94598
(925) 943-6800, FAX (925) 943-6880

20130 LAKE CHABOT RD., SUITE 303
CASTRO VALLEY, CA 94546
(510) 733-1888, FAX (510) 881-5332

491 30TH STREET, SUITE 102
OAKLAND, CA 94609
(510) 832-6554, FAX (510) 832-3119

1460 NO CAMINO ALTO, SUITE 206
VALLEJO, CA 94589
(707) 552-9596, FAX (707) 552-9599

39055 HASTINGS PLAZA, SUITE 105
FREMONT, CA 94538
(510) 505-1430, FAX (510) 794-6264

2219 BUCHANAN ROAD, SUITE 6
ANTIOCH, CA 94509
(925) 522-8850, FAX (925) 522-8851

15051 HESPERIAN BLVD., SUITE D
SAN LEANDRO, CA 94578
(510) 317-1111, FAX (510) 317-1113

5980 STONERIDGE DRIVE, SUITE 117
PLEASANTON, CA 94588
(925) 463-8200, FAX (925) 463-8201