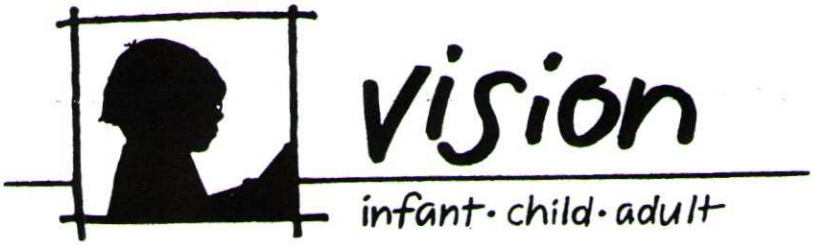

Patient Name: _____ Date of Birth: _____
Address: _____ SS#: _____
City/State/Zip Code: _____ Telephone: _____

DATE OF SERVICE: _____

☐ Dr. Penelope Suter, Dr. Alyssa Nguyen, and/or Dr. Virginie Dang would like to **release** information to:
☐ Dr. Penelope Suter, Dr. Alyssa Nguyen, and/or Dr. Virginie Dang would like to **obtain** information from:

Name of Provider/Organization/Person: _____
Address: _____
City/State/Zip Code: _____
Telephone: _____ Fax: _____

Purpose of Request for Information: Healthcare ☐ Insurance ☐

This exchange may be by telephone, fax, letter, or electronic transmission. This authorization is given on my own free will, and is valid for one (1) year from today's date unless terminated in writing. I understand that I have the right to request a copy, and that I can revoke this authorization in writing at any time. A photocopy is as valid as the original. I hereby release the above parties from any liability incurred as a result of this release.

This information is limited to:

- ☐ Entire Records
- ☐ Visual Records
- ☐ Insurance Information
- ☐ Other (specify): _____

I am **referring** the above patient to your office for the following reasons:

I will appreciate receiving the report of your findings.

Doctor Signature: _____

I authorize Dr. Penelope Suter, Dr. Alyssa Nguyen, and/or Dr. Virginie Dang to **exchange** information with above mentioned Provider, Organization, and/or Person. I have the right to refuse to sign this form and understand that my signature is not a condition of treatment. I further understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Rule although such information may be protected under applicable California Law.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____
NOTE: If patient is a minor, parent or legal guardian must sign this form. A copy of the document establishing legal custody or guardianship must be attached.

PENELOPE S. SUTER, O.D., F.C.O.V.D., F.A.B.D.A., F.N.O.R.A.

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