



Nora M.Y. Chan, O.D, Inc.
377 Keahole Street
Honolulu, HI 96825
Phone: (808)396-6311
Fax: (808)395-2448

*Associates: Peili Lin, O.D.
Elise Lew-Louie, O.D.*

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____ Fax: _____

Patient Name: _____ DOB: _____

Ophthalmology Records including visual fields

Eyeglass Prescription

Medical Hx

I, _____, request that the following above checked items be released to:

Nora M.Y. Chan
Honolulu Vision Care Center
377 Keahole Street
Honolulu, HI 96825
Fax: 808-395-2448

Signature: _____ Date: _____

This communication is only for the above addressed individual and may contain information that is privileged, confidential, and/or prohibited from disclosure. If the reader of this communication is not the intended recipient, you are prohibited from using it in any way. If you have received this communication in error, please notify the sender immediately by telephone and return the original message to us at the above address. We will reimburse you for any cost you incur in returning the facsimile to us. Thank you.