



Advanced Valley Eye Associates

Robert B. Miller, M.D.

RELEASE OF OPHTHALMIC MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

I hereby authorize you to release from:

TO:

Robert B. Miller, M.D.
2035 Lyndell Terrace, Suite 100
Davis, CA 95616
530-757-6000
530-231-5873 - fax

Any information, including the diagnosis and records of any treatment or examination,
rendered to me during the period:

- From: _____ to
- The past 12 months
- No time limitations, send ALL ophthalmic records (including visual fields)

Patient Signature

Date