CLOMPUS
RETO &
HALSCHEID
Vision Associates, P.C.

DRY EYE CENTER of EXCELLENCE

OPTOMETRY

STEVEN J. RETO, O.D., F.A.A.O.
Comprehensive Exams, Medical Treatment, Glaucoma and Contact Lenses

HARRY N. HALSCHEID, O.D., F.A.A.O.
Comprehensive Exams, Medical Treatment, Glaucoma, Contact Lenses and Low Vision Rehabilitation

MITCHELL M. SCHEIMAN, O.D., F.C.O.V.D.
Pediatric Optometry and Vision Therapy

KERRI E. BAKKER, O.D.
Comprehensive Exams, Medical Treatment, Glaucoma, Contact Lenses and Dry Eye Management

BENJAMIN A. FOREMAN, O.D.
Comprehensive Exam, Medical Treatment, Glaucoma & Specialty Contact Lenses

OPHTHALMOLOGY

BRUCE R. SARAN, M.D.
Macular Degeneration and Diseases and Surgery of the Retina and Vitreous

RECORD RELEASE AUTHORIZATION

Date: _____

To: Clompus, Reto and Halscheid Vision Associates

I hereby authorize and request you to release my medical records to the following office at the address below:

Office Name: _____

Office Address: _____

Office Fax/Phone: _____/_____

Patient's Name: _____

Date of Birth: _____

Signature: _____
(Patient or Legal Guardian)

Witness: _____

WEST CHESTER
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Exton
93 West Devon Drive, Suite 101 • Exton, PA 19341 • Voice: 610.363.8960 • Fax: 610.363.8962

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