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: _____

_____

(Address)

I hereby authorize and request you to release my medical records to:

Clompus, Reto & Halscheid Vision Associates, P.C.
93 West Devon Drive, Suite 101
Exton, PA 19341

The complete medical record(s) in your possession, concerning my illness and/or treatment.

Patient's Name: _____

Date of Birth : _____

Signature: _____
(Patient or Legal Guardian)

Witness: _____

WEST CHESTER
Goshen Executive Center • 1450 East Boot Road, 700B • West Chester, PA 19380 • Voice: 610.696.1368 • Fax: 610.430.2079

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

Website: www.crhvision.com