Authorization for Disclosure of Patient Health Care Information

Name of Patient: _____ Physician Initials:_____

Date of Birth: _____ Phone Number: _____

Street Address: _____ City, State, Zip Code: _____

Fishkind, Bakewell, Maltzman, Hunter & Associates
Eye Care & Surgery Center

5599 N. Oracle Road, Tucson, AZ, 85704

10425 N. Oracle Road, Tucson, AZ, 85737

Phone Number (520) 293-6740

Fax Number (520) 293-6771

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****The information in this box MUST BE FULLY COMPLETED. We are not able to process record requests without complete contact information.****

Release to: ___ Obtain from: ___

Name of Health Care Facility/Physician:

_____

Address: _____

_____

Phone Number: _____

Fax Number: _____

Check all that apply: **Please mail records over 25 pages**

_____ Last 2 years of Records (if more needed please specify below)

_____ Diagnostic Testing

_____ Previous Surgery Notes Other _____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

All my health information including, but not limited to, AIDS/HIV & other communicable disease information, Behavioral health care/psychiatric care, alcohol &/or drug abuse treatment, if any, unless specifically noted.

_____

Purpose or need for disclosure: (check applicable categories)

___ Further medical care ___ Personal ___Legal Investigation Other_____

I understand that this authorization shall be valid for 1 year unless otherwise stated below, or revoked through written notice to Medical Records. (Alternate date if not 1 year)_____

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Signature of patient: _____ Date: _____

Authorized Signature: _____ Relationship: _____

If signed by person other than patient, state relationship and authorization to do so.