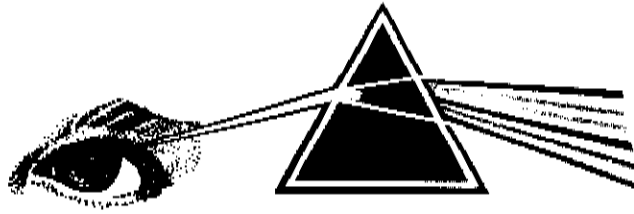


COCHISE EYE & LASER



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Medical Records Release Authorization - Fax: 520-458-0422

I hereby authorize the use or disclosure of my individual health information as described below. I am aware that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient's Name

Date of Birth

Patient's Address

_____ is authorized to release to _____

Information to be Released:

All clinic records Visual Fields Lab reports X-ray reports
 Photographs Specify other _____

Purpose or Need for Disclosure:

Further medical care Legal investigation Application for insurance
 Vocational Rehab evaluation Disability determination Employer
 Payment of insurance claim Personal Specify other _____

Expiration Date:

This authorization is valid for (1) year unless otherwise noted: _____

Revocation

This authorization may be revoked at any time by notifying Cochise Eye & Laser in writing at the address listed above. If I revoke this authorization, I understand that it will not have any effect on actions Cochise Eye & Laser took before it received the revocation.

Patient's Signature (or Patient's Representative)

Date

Name of Patient's Representative (please print)

If Patient Representative, what is your legal authority?

Power of Attorney Legal Guardian Next of Kin of Deceased
 Other _____