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 _____