Authorization for Disclosure of Patient Health Care Information

ORACLE EYE
PHYSICIANS & SURGEONS

Physician Initials_____

5599 N Oracle Rd, Tucson, AZ 85704
10425 N Oracle Rd Suite 135, Oro Valley, AZ 85737
Phone: 520.293.6740 **Fax:** 520.293.6771

Name of Patient: _____ **Date of Birth:** _____

Phone number: _____

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

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

Please check one:

Release to: ○ or 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 includes, but not limited to, AIDS/HIV & other communicable disease information, Behavioral health care/psychiatric care, alcohol &/or drug abuse treatment, 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 the 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.