

Authorization for Disclosure of Patient Health Care Information

Name of Patient: _____

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

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.