RECORDS RELEASE MEDICAL AUTHORIZATION

Patient Name: ________________________________ Date of Birth: ___________________________

Address: ____

City: __________________ State: __________ Zip: __________ Phone: ___________________

Patient/Guardian's Signature: ______________________ **Date**: ______________________

Which records are needed:

- ❑ Complete Medical Records
- ❑ Records From __________ to __________
- ❑ Visual Field/Testing

Reason for Transfer/Request:

- ❑ Continuing of Care
- ❑ Insurance
- ❑ Referral
- ❑ Personal Use

I, the undersigned, do hereby authorize and direct you to:

[ ] Furnish records **TO** Tozer Eye Center

[ ] Release records **FROM** Tozer Eye Center

I UNDERSTAND THAT TOZER EYE CENTER DOES NOT RELEASE COPIES OF RECORDS RECEIVED FROM OTHER HEALTH CARE PROVIDERS.

PLEASE CONTACT THOSE PROVIDERS FOR ANY OTHER RECORDS.

PROVIDER INFORMATION:

Name: ____

Address: ____

City: ______________________ State: ________ Zip: ________________

Phone: ______________________________ Fax: ________________________________

Check how records are to be received: Mail [ ] Pick-Up [ ] Fax [ ]

Tozer Eye Center
9811 N. 95th ST. Ste. 101
Scottsdale, AZ 85258
Phone: 480-947-4493 Fax: 480-947-4751

I understand that my request will be processed within the time frames set forth by state law or within 30 days, whichever is less.
I understand that by signing this authorization my treatment, payment and enrollment in a health plan or eligibility for benefits will not be conditioned upon authorization of this disclosure.
I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would the no longer be protected by federal privacy regulations.

A Copy of this authorization is as valid as an original and will expire 1 year from the date