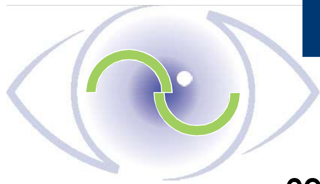

<u>**PLEASE FAX THIS FORM BACK WITH RECORDS TO **(480) 393-5144****</u>

CONFIDENTIAL Authorization for Disclosure of Protected Health Information.

This form is used to request copies of medical records. Only patients or their legal representative may make a medical record request. **Eye Physicians & Surgeons of Arizona** may verify your identity/guardianship. **Please print.**

PATIENT INFORMATION	Patient Name Date of Birth Phone number Address City State Zip Code
INFORMATION REQUESTED	☐ Complete Medical Records ☐ Records from (date):__________ to (date): __________
PURPOSE OF REQUEST	☐ Self ☐ Continuation of Care ☐ Other (specify) __________

RELEASE TO:	**RELEASE FROM:**
Name	Name
Phone Fax	Phone Fax
Address	Address
City State Zip Code	City State Zip Code

I hereby authorize the release of my complete medical records in your possession. This authorization is valid 6 months from the date of signature. It may take up to 30 days from date of receipt to release your records.

Patient Signature **Date**

Legal Representative:

Relationship to patient: __________

For EPSA use only:

Records sent by:__________ Date:__________

Method of release: ☐ FAX ☐ MAIL ☐ SELF PICK UP