

Goodyear Eye Specialists Medical Records Release

13657 W. McDowell Rd. Ste. 209
Goodyear, AZ 85395
Phone #: (623) 533-4666 Fax #: (623) 455-9152

(Name of Patient)

(Birthdate)

(Street Address)

(City, State, Zip Code)

Authorizes:

Release of Records to:

(Name of Physician or Health Care Facility)

(Name of Physician or Health Care Facility)

(Street Address)

(Street Address)

(City, State, Zip Code)

(City, State, Zip Code)

Information to be released:

All Clinic Records Office Photographs Visual Fields Other (Specify)

List other facilities' records to be included when releasing for the purpose of continuing medical care:

For the following dates: _____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

Mental Health AIDS-related disease AIDS test results Developmental Disability
 Drug Abuse diagnosis Alcoholism Other (specify)

Purpose or need for disclosure: (Check all applicable)

Further Medical Care Vocational rehabilitation Legal Investigation
 Application for Insurance evaluation Other (specify)
 Disability Determination Personal

I understand that this authorization is valid for one (1) year unless otherwise state below or revoked through written notice to the Privacy Officer of the Practice.

(Alternate date if not one year)

Please note, HIPAA does not allow this organization to condition treatment, payment, enrollment, or eligibility for benefits upon receiving this authorization. The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this for you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior authorization.

Signature of Patient: _____ **Date:** _____
(If signed by person other than patient, state relationship and authorization to do so)

(Authorized signature)

(Relationship)

Patient is: Minor Incompetent Disabled Deceased
Legal Authority: Legal Legal Guardian Next of kin of deceased