PLEASE FAX THIS FORM BACK WITH RECORDS

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 _____ Address _____ City State Zip
INFORMATION REQUESTED	☐ Complete Medical Records ☐ Records from (date) _____ to (date) _____
PURPOSE OF REQUEST	☐ Self ☐ Continuation of care ☐ Other (specify)

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

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 Printed Name and Signature (if applicable) Relationship to patient

For EPSA use only:
Records sent by: _____ Date_____
Method of release: ☐ Fax ☐ Mail ☐ Self Pick up