PLEASE FAX THIS FORM BACK WITH RECORDS TO (480) 393-5144

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