Envision Eyecare Center, P.C.
525 West Wetmore Road
Tucson, AZ 85705
Phone: 520-293-2363
FAX: 520-293-0475
www.envisioneyecarecenter.com

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: __________________________ Date of Birth: ________________________

Address: _______________________________ City, State, Zip: _____________________

**Release Medical Records From:**

Envision Eyecare Center, P.C.
525 W Wetmore Road
Tucson, AZ 85705

**Release Medical Records to:**

_____________________________________

_____________________________________

_____________________________________

Information to be Released:

_____ Complete Medical Records (Fees May Apply)     Other: ________________________________________

Purpose for Disclosure:

_____ Further Medical Care     _____ Personal Copy     _____ Attorney
_____ Insurance Reasons     _____ Disability Determination     _____ Other

I agree that any information regarding drug and/or alcohol abuse, communicable disease(s), psychiatric, and/or HIV/AIDS, Genetic Testing may be released.
______ Yes (Initials) _____ No (Initials)

I agree that any medical billing record(s) containing information in reference to drug and/or alcohol abuse, communicable disease(s), psychiatric, and/or HIV/AIDS, Genetic Testing may be released.
______ Yes (Initials) _____ No (Initials)

I further authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to revoke this request. Additionally, I hold harmless Envision Eyecare Center, P.C., its agents and employees from any recourse due to any loss, claims for injury or damage, costs, expenses, neglect, or injury or damage caused by intentional acts or omissions.

**NOTICE**

Health organizations are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

_____________________________________     ________________________________________
Print Name     Signature (Patient, Parent, Guardian)

_____________     ________________________________________________________
Date     Relationship to Patient
(Parent, Guardian, Conservator, Patient Representative)

For Internal Use: Information released: ________/________
Initials Date