AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth:_____

Address: _____ City_____, State_____, Zip: _____

Release Medical Records From: **Hodges Eye Care & Surgical Center**

1502 N. Tucson Blvd., Tucson, AZ 85716

Release Medical Records To: _____

_____

_____

Information to be Released: Complete Medical Records: _____Other:_____(Fees May Apply)

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 Hodges Eye Care and Surgical Center, 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.

Signature of Patient: _____ Date: _____

Authorized Signature: _____ Relationship: _____

Office: 520-326-4321 Fax: 520-326-4736