## **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: Comple	te 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 d	Irug and/or alcohol abuse, communicable o	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 Tes	ting may be released.
Yes (Initials) No (Initials)		
I further authorize release of my medica understand written notice is necessary t	al records in accordance with the specificat to revoke this request.	ions listed above. I
,,	e Care and Surgical Center, its agents and e age, costs, expenses, neglect, or injury or o	· · ·
Signature of Patient:	Date:	
Authorized Signature:	Relationship:	

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