FLAGSTAFF EYE CARE
Established 1955

Authorization to Release Medical Records

410 N. San Francisco St., Flagstaff, AZ 86001
Phone #: (928)774-5093 / Fax #: (928)774-8321

Patient Name: _____ **Date of Birth**: _____

INFORMATION TO BE RELEASED FROM:

Name:_____

Address: _____

Phone#: _____ Fax#: _____

INFORMATION TO BE RELEASED TO:

Name:_____

Address: _____

Phone#: _____ Fax#: _____

INFORMATION TO BE RELEASED (CHECK ONE):

____ The most recent two years of pertinent information

____ All medical records

____ Specific information (please specify):_____

_____

PATIENT AUTHORIZATION:

By signing below, I hereby give my specific authorization for these records to be released.

Signature: _____ **Date**: _____

IMPORTANT: This records release contains confidential information, some or all of which may be protected health information as defined by the Federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, or confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution, or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.