Canyon Eye Associates

Authorization to Release Medical Records

Patient Name: _____ **DOB**: _____ **SS#** _____

I hereby authorize **Canyon Eye Associates** to:

- ☐ Release my medical records to: _____
- ☐ Obtain my medical records from: _____

Facility / Provider Information

Facility/Provider Name: _____

Address: _____

Phone: _____ Fax: _____

Information to be Released

- ☐ Complete Medical Record
- ☐ Surgical Records
- ☐ Medication List
- ☐ Eye Care & Treatments
- ☐ Office Notes
- ☐ Diagnostic Testing/Imaging
- ☐ Insurance Information
- ☐ Other: _____

Purpose of Disclosure

- ☐ Continuing Medical Care
- ☐ Insurance/Billing
- ☐ Other: _____
- ☐ Referral/Consultation
- ☐ Personal Use

Method of Release

- ☐ Fax (to the number above)
- ☐ Mail
- ☐ Pick Up (Photo ID Required)
- ☐ Secure E-Mail to: _____

Records are only sent by secure email if a signed Patient Acknowledgements & Consents form allow email communication is on file.

Patient Acknowledgement & Understanding

I understand that this authorization is voluntary. I may revoke this authorization at any time in writing, except to the extent action has already been taken. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. Information disclosed pursuant to this authorization may no longer be protected by federal privacy regulations once released to the recipient. This authorization shall expire one (1) year from the date of signature unless revoked earlier in writing by the patient or legal representative

_____ _____

Patient/Legal Representative Signature Date

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