



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

Office Notes

Surgical Records

Diagnostic Testing/Imaging

Medication List

Insurance Information

Eye Care & Treatments

Other: _____

Purpose of Disclosure

Continuing Medical Care

Referral/Consultation

Insurance/Billing

Personal Use

Other: _____

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. 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