Arizona's Vision
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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth_____

Address: _____

Phone: _____

I authorize the professional office of Arizona's Vision to ____ OBTAIN information from
____ RELEASE information to

Individual/Agency: _____

_____

_____

Phone: _____ Fax: _____

Specific information to be released _____

_____

This consent is subject to written revocation by the undersigned at any time except to the extent that the action has been taken, and if not earlier revoked. This consent shall become invalid ninety days from the date of signature. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above. I understand that I may review the disclosed information by contacting the physician, institution or agency named above. I understand that I have the right of the patient to inspect the disclosed material.

Signature: _____ Date: _____
(Patient/Guardian if under 18)

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient: _____

Printed Name: _____

Source of authority: _____