Desert Vista Eye Specialists, PC

Dr. Lawrence S. Kahn, M.D
certified, American Board of Opthamology
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certified, American Board of Opthamology

MEDICAL RECORDS RELEASE

Last Name ______________________ First Name ______________________ MI ______

Address 1 ____

City ______________________ State ____________ Zip ____________

AUTHORIZES:

Physician ______________________ Health Care Facility ______________________

Address ____

RELEASE RECORDS TO:

Physician ______________________ Health Care Facility ______________________

Address ____

INFORMATION TO BE RELEASED:

☐ All Clinic Records ☐ Photographs ☐ Visual Fields

☐ Eye Records ☐ Office notes ☐ Other

List other facilities record to be released for purpose of continuing medical care and for the following dates.

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In compliance with state statutes which require special permission to release otherwise privileged information

RELEASE RECORDS PERTAINING TO:

☐ Mental health ☐ AIDS test results ☐ Drug Abuse

☐ Developmental disabilities ☐ AIDS related disease diagnosis ☐ Other

☐ Alcoholism

PURPOSE FOR DISCLOSURE: (check applicable categories)

☐ Further Medical Care ☐ Payment of Insurance Claim ☐ Legal Investigation

☐ Application for Insurance ☐ Vocational Rehabilitation evaluation ☐ Other

☐ Disability Termination ☐ Personal

I understand that this authorization shall be valid for one year unless otherwise stated below or revoked through written notice to medical records. ______________________

(Alternate date if not one year)

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Signature of Patient ______________________ **Date** ______________________

If signed by person other than patient, state relationship and authorization to do so.

Authorized Signature ______________________ **Relationship** ______________________

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Legal ☐ Legal Guardian ☐ Next of kin of Deceased.

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