AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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5620 East Broadway Road
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Telephone: (480) 981-6111 FAX: (480) 985-2426

Printed Patient Name: _____

Date of Birth: _____ Today's Date: _____

I hereby authorize (Name of Physician or Hospital): _____

Street Address or PO Box: _____

City, State and Zip Code: _____

FAX: _____ Telephone: _____

To furnish East Valley Ophthalmology the information indicated below during the period:

From _____ to the present.

Medical records, operative reports, consultations with other physicians,
Visual field testing, glaucoma flow charts, optic nerve photography, OCT studies,
IOL power measurements, laboratory studies, x-ray reports, MRI and CT scanning reports.

Signature of Patient: _____

Signature of Witness: _____

☐ In rare and unusual circumstances, our office sometimes needs medical information sent to us in an expedited manner. If the box to the left has been checked, we would ask that you please FAX this information to our office at (480) 985-2426 as soon as possible. This extra effort on your part is greatly appreciated.

Please send this information to the attention of: _____