RETINA SPECIALISTS
OF SOUTHERN ARIZONA

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

Date of Birth: _____

Phone Number: _____

Date of Request: _____ **Date Needed:** _____

☐ I authorize Retina Specialists of Southern Arizona to ***obtain information from:***	OR	☐ I authorize Retina Specialists of Southern Arizona to ***release information to:***
Name of Provider or Facility		Name of Provider or Facility
Address		Address
City, State ZIP		City, State ZIP
Phone/Fax (include area code)		Phone/Fax (include area code)

Please submit medical records via fax to (520) 881-1418

Type of records requested: (check one)

☐ Treatment summary ☐ Entire medical record

☐ Specific information (please describe):_____

Authorization valid for: (check one)

☐ This request only.

☐ This request **and** for medical records of any **future** treatment until I cancel this authorization in writing.

Signature of Patient or Representative: _____

Relationship to Patient *(if requestor is not patient):* _____

Date:_____