Eye Associates of Tucson

Records Release
Patient Health Care Information

Eastside 520-795-4202/ (Fax)520-326-5317
Northwest 520-888-6600/(Fax) 520-888-9545

Printed Name: _____ Date of Birth: _____
Street Address: _____
City, State, Zip Code: _____ Telephone: _____

1. **Information to be Disclosed-Covering the Periods of Health Care:** (*There may be a fee for copying these records).*
   From (date) _____ To (date) _____
   - ☐ Complete Health Record(s)
   - ☐ History and Physical Examination
   - ☐ Consultation Reports
   - ☐ Photographs, videotapes, digital/other images
   - ☐ Other _____ *(please specify)*
   - ☐ Progress Notes
   - ☐ Laboratory Tests
   - ☐ X-ray Films ☐ Reports only
   - ☐ Billing Records

2. **Purpose of Request:**
   - ☐ Treatment/Consultation
   - ☐ Insurance Copy
   - ☐ Attorney
   - ☐ Personal Copy
   - ☐ Other _____

3. **Person Authorized to Disclose Information:** _____ **Person Authorized to Receive Information:** _____

4. **Drug and/or Alcohol Abuse, Communicable Disease, Psychiatric, and/or HIV/AIDS/Genetic Testing Release:**
   I agree that any information regarding Drug and/or Alcohol Abuse, Communicable Diseases, Psychiatric and/or Genetic Testing may be released.
   _____ Yes (*initials*) _____ No (*initials*)

   I agree that any medical or billing record containing information in reference to HIV/AIDS (Human Immuno-Deficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment may be released.
   _____ Yes (*initials*) _____ No (*initials*)

5. **Time Limit & Right to Revoke Authorization:**
   I understand that I can revoke this authorization at any time by submitting a written notice to the Custodian of Records at the location where records are located; However, I understand that if I do not act quickly to revoke this authorization, my records may have already been released.

   Unless revoked, this authorization will be valid until the information is released.

6. **Re-disclosure:**
   I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. UPI, its employees, officers and physicians are hereby released form any legal responsibility for disclosure of the above information.

7. **Signature of Patient or Personal Representative Who May Request Disclosure:**
   Signature _____ Date _____
   Print _____ Authority to sign if not Patient _____

8. **Identity of Requestor Verified:**
   ☐ Photo ID ☐ Matching ID ☐ Other _____ *(please specify)*
   Verified By: _____