Patient Name: _____D.O.B._____SSN:_____

This authorization allows the healthcare provider(s) named below to release confidential information and records.
I hereby authorize: _____
Physician/Medical Group

_____
Street Address

_____
City State Zip

_____
Telephone Fax

To release information listed below from my medical records by means of mail or fax to:

CITRUS VALLEY EYECARE
475 West Badillo Street
Covina, CA 91723
(626)732-2200 OR (626)966-7422

Please provide the following information:

☐ History ☐ Visual Fields ☐ A-Scan reports
☐ Operative Reports ☐ Fluorescein Angiography reports ☐ Other
☐ Clinic Notes ☐ OCT reports

The medical information/records will be used for the purpose of continuation of care.

Time Period:
This authorization shall be effective immediately and will remain in effect until:
_____.

Restrictions:
Permission for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of Patient or Legal Representative Relationship to Patient

_____ _____
Print Patient Name Date