Dr. Tina Cooley-Staley, O.D. & Dr. Stacie Eskew, O.D.
1780 E. Boston Street Ste101, Gilbert, AZ 85295
480-813-7050

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME _____ _____ _____ ACCT#_____
Last First MI

PATIENTS DATE OF BIRTH _ _____ SOCIAL SECURITY # _____

PHONE #_____ EMAIL _____

PATIENT'S ADDRESS _____

CITY _____ STATE _____ ZIP _____

PLEASE CHECK APPROPRIATE BOX

☐ I hereby authorize Val Vista Vision to send / release photocopies of medical records concerning the above named patient to NAMED RECEIVER LISTED BELOW.

☐ I hereby authorize THE PROVIDER LISTED BELOW to send / release photocopies of medical records for the above named patient to Val Vista Vision.

(NAME OF COMPANY / PHYSICIAN / AUTHORIZED PERSON / TO RECEIVE / RELEASE RECORDS)

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____

EMAIL _____

FOR PURPOSES OF _____

FOR THE PURPOSES HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL:

1. CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661).
2. CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661).
3. CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ER SEQ).
4. CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.
5. CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-2801).

___ MEDICAL RECORDS OF THE LAST TWO YEARS (and/or)

___ THE FOLLOWING DESCRIBED RECORDS (specify types and dates) _____
_____

This consent will expire (90) days after the signed date below. I may revoke this authorization at any time providing I notify the above listed in writing to that effect. I understand that any release made prior to my revocation in compliance with this authorization shall not constitute a breach of my right to confidentiality. **I HEREBY RELEASE VAL VISTA VISION FROM ALL LEGAL RESPONSIBITLIY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.**

_____ _____
Signature of Patient Date Signed

_____ _____
Parent / Legally Authorized Representative Relationship to Patient

Reason patient was unable to sign release _____
PATIENT 18 YEARS AND OLDER MUST SIGN OWN RELEASE

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