Premier Eye Center

Matthew R. Sullivan, O. D., P.C.
Premier Eye Center
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(928)778-3937
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Date_____

Patient Identification	Name: _____ Date of Birth: _____S.S. # _____
Provider **(Who is releasing information)**	Name: _____ Address:_____ City/State/Zip:_____ Telephone:_____ Fax: _____
Release Records To: (Person or Place records should be sent)	**Premier Eye Center** Matt Sullivan, O.D. Kelsie Stevens, O.D. Lauren West, O.D. Shane Sanders, O.D.

Date(s) of Services Requested (if known) or Provider: _____

Description of Information to be Released: **(If larger than 35 pages please mail)**

- Last _____Years
- Dictated Summary of most recent exams and pertinent medical history.
- Special Test (Visual Fields, GDX, HRT, Photographs, etc.)
- Other : _____

Purpose of Release

- Medical Care
- Insurance
- At the request of patient
- Other: _____

I understand that my medical record may also include information on diagnosis/treatment related to behavioral or mental health, alcohol/drug abuse, communicable disease, acquired immune deficiency syndrome (AIDS), and/or HIV status.
I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.
I understand that information used or disclosed pursuant to the authorization my be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulation.

Time Limit

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date _____.

_____ _____

Printed Name of Patient/Patient's Representative
Relationship to Patient: _____

Signature of Patient/Patient's Representative
Date _____

Witness _____