AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I authorize Southwestern Eye Center to disclose the following information:

<table>
<tr><td rowspan="4">PATIENT INFORMATION</td><td>_______________________________
Patient Name   ID</td></tr>
<tr><td>_______________________________
Date of Birth   Phone</td></tr>
<tr><td>_______________________________
Address</td></tr>
<tr><td>_______________________________
City   State   Zip</td></tr>
<tr><td>INFORMATION REQUESTED</td><td>☐ Chart Notes   ☐ Dictation   ☐ Complete Medical Records
☐ Records from (date) ______________________ to (date) ______________________</td></tr>
<tr><td>PURPOSE OF REQUEST</td><td>☐ Self   ☐ Continuing Medical Care
☐ Other (specify):____</td></tr>
</table>

RELEASE TO:	RELEASE FROM:
______________________________	______________________________
Name	Name
______________________________	______________________________
Phone Fax	Phone Fax
______________________________	______________________________
Address	Address
______________________________	______________________________
City State Zip	City State Zip

Time Limit & Right to Revoke Authorization: Unless revoked, this authorization will be valid until the information is released. To revoke this authorization, I must submit in writing to Southwestern Eye Center, Medical Records Dept, 2610 E. University Dr., Mesa AZ 85213, or to the site where I submitted the authorization.

Re-disclosure: I understand 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. I release Southwestern Eye Center, its employees, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Service Charge: I understand that, as a courtesy to its patients, Southwestern Eye Center offers one set of copies free of charge during a service period. Should I be seen again within a 12-month period of requesting my records and make a new request for records, Southwestern Eye Center will provide a copy of all **new** records since the file was last copied free of charge.

____   ______________________
Patient Signature   Date

____   ______________________
Legal Representative Printed Name **and** Signature (if applicable)   Relationship to Patient

For SEC Use Only: MR#:______________________________

Identity of requestor verified via: ❑ Photo ID ❑ Matching Signature ❑ Other (specify): _____________

Records sent by (print name) ________________________ on (date ______________________

Method of Release: ❑ Fax ❑ UPS / FEDEX (circle one) ❑ Self pick up