SunCityWest
EYE CARE

13576 W Camino Del Sol Ste 12 · Sun City West, AZ 85375
Phone: (623) 544-3877 · Fax: (623) 544-3834

THIRD PARTY RECORDS RELEASE

Date:

Patient Information
Patient Name:
Gender: M or F DOB:
Patient Address/State/Zip
Patient phone:
I request and authorize Donald J. Siegel, OD to receive health care information of the patient named above from:
Name:
Phone: Fax
Address/City/State/Zip

This request and authorization applies to:
□ All health care information
□ Health care information relating to the following treatment, condition, or dates of treatment:
_____
□ Other: Most recent exam notes

I understand that my express consent is required to release any health information relating to testing, diagnosis, and/or psychiatric disorders/mental health, or drug and /or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

_____ Date: _____
Signature of patient or patient's authorized representative

_____ Date: _____
Witness Signature

This authorization expires 30 days after the date it is signed