

**General Medical Records Release and
Authorization for Use or Disclosure of Protected Health Information**

Please complete the following information:

Patient Name: _____

Address: _____

Phone: _____

Date of Birth: ____/____/____

I authorize the custodian of records at:

to disclose/release my health information to California Eye Surgeons

These records are for services provided on the following date(s): _____

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Please send the records listed above to:

**California Eye Surgeons
5330 Camden Ave,
San Jose, CA 95124
phone: 408-940-3930
fax: 408-940-3945**

Patient/Guardian Signature

Patient/Guardian Name

Date

Putting Patient Care First

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