CALIFORNIA
Eye Surgeons

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 California Eye Surgeons to release my health information to:

_____

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.

_____	_____	_____
Patient/Guardian Signature	Patient/Guardian Name	Date

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