PACIFIC EYE ASSOCIATES

2100 Webster Street, Suite 214
San Francisco, CA 94115
Phone: (415) 923-3007
Fax: (415) 923-6586

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize

_____
(provider)

To release medical records to:

_____

_____

_____

Patient Name _____

Date of Birth _____ Telephone _____

Information to be disclosed:

- ☐ Complete medical records
- ☐ Progress notes
- ☐ History and physical examination
- ☐ Consultation reports
- ☐ X-ray reports
- ☐ Laboratory reports
- ☐ Discharge summary
- ☐ Photos, videotapes, digital images, etc.
- ☐ Other (specify)

I understand that this will include information relating to (check if applicable):

- ☐ acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection
- ☐ behavioral health services/psychiatric care
- ☐ treatment for alcohol and/or drug abuse

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: X_____
Patient Date

_____
or legal representative Date