Eyes on Queen Creek, PLLC
Fax: (480) 323-2011

Authorization for Use and Release of Health Information

Patient Name _____Date of Birth_____
Address_____
Patient Phone Number _____Today's Date_____

I authorize Eyes on Queen Creek, PLLC to disclose or request my protected health information to the person or class of persons listed below for the purpose of

_____.

Name of Person or Facility:		
Practice Address:		
Phone:	Fax:	Email:

Please select the documents that apply to your request:

□ Eyeglass Prescription □ Contact Lens Prescription □ Eye Exam Record

□ Retinal Photos □ OCT result □ Visual Field result

□ Other: _____

I would like the records from □ the last eye exam □ from ___/ ___/ ____ to ___/ ___/ ____

Requestor's Printed Name: _____ Signature:_____
Relationship to Patient: □ Self □ Guardian

Please fax a signed copy of this form to (480) 323-2011 or upload it to the patient portal.