East Valley Ophthalmology, Ltd.

Medical Information Release

Today's Date: _____

Printed Patient Name: _____

Patient Signature: _____

During the course of your care in our office, you may wish to have a family member, or a friend, assist you in scheduling appointments, setting up procedures, or obtaining medical information.

An authorization is necessary for our staff to release any information regarding your care.

Please list below any person(s) to whom you authorize the release of information regarding your care with East Valley Ophthalmology, Ltd.

Name	Relationship to Patient	Date of Authorization	Revoke
			☐
			☐
			☐
			☐
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			☐
			☐
			☐