



**EYES ON
SUNSET**

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
MEDICAL RECORD RELEASE

PATIENT NAME:

DATE OF BIRTH:

ADDRESS:

CITY/STATE/ZIP:

PHONE:

I request and authorize the provider/clinic indicated below to release health information to Eyes on Sunset:

Provider or Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

**** PLEASE EMAIL ALL RETINAL PHOTOS TO HELLO@EYESONSUNSET.COM ****

Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below or on the following date, event, or condition:

I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

Patient or Legal Guardian's Signature

Date