city of vision eye care

cov@swcp.com
www.cityofvision.com

4025 Jackie Road SE, Rio Rancho, NM 87124
P: (505) 892-8411 F: (505) 375-4793

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____ E-mail: _____

INFORMATION TO BE RELEASED FROM

Organization: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ E-mail _____

INFORMATION TO BE RELEASED TO

PURPOSE OF RELEASE ◯ Transfer of Care ◯ Copies for own use ◯ Other: _____

◯ Office Pick Up ◯ Fax ◯ Secure Email ◯ Mail - mailing fees apply

Date Needed by _____ (allow 7-10 business days for processing)

Organization: _____

Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ E-mail _____

MY RIGHTS / MY AUTHORIZATION

I, _____ (print name), hereby grant permission for the release confidential health information, by releasing a copy of the named patient above medical records, or a summary or a narrative of the patients protected health information, to the physician / person / facility / entity.

Signature of Patient: _____ Date: _____

Signature of Patient Representative: _____ Date: _____

Relationship to patient: ◯ Self ◯ Spouse ◯ Guardian ◯ Other: _____