CALIFORNIA
Eye Surgeons

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: ____

Address: ____

____

Phone: ____

SSN (last 4 digits): ____________________________________Date of Birth:_____/_____/_____

I authorize the custodian of records at:

____

to disclose/release my health information to California Eye Surgeons at 555 Knowles Dr. Suite 117, Los Gatos, CA 95032.

These records are for services provided on the following date(s): ____________________________

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider's Privacy Office at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Please send the records listed above to:

California Eye Surgeons
555 Knowles Dr. Suite 117
Los Gatos, CA 95032
phone: 408-940-3930
fax: 408-940-3945

______________________________	________________________	__________
Patient/Guardian Signature	Patient/Guardian Name	Date

Putting Patient Care First

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