If you feel it would be beneficial to your care for us to request previous records, please fill out the following:

RECORDS RELEASE REQUEST

Requesting From:_____ Phone Number:_____
(Doctor/Hospital)

Address:_____

City:_____ State:_____ Zip:_____

I hereby authorize the release of my copied medical records.
I request that they be transferred to:

Eye Priority
15815 S. 46th St. Ste 116
Phoenix, AZ 85048
Telephone: 480-893-2300
Fax: 480-893-0522

_____
Printed Name of Patient

Date of Records From: _____ To:_____

_____
Patient's Signature

This authorization shall be considered valid for 12 months from date signed