ARVADA
VISION & EYE CLINIC

5801 Olde Wadsworth Blvd
Arvada, Colorado 80003
(303) 422-3817 Telephone
(303) 423-6317 Fax
www.arvadavison.com

AUTHORIZATION TO OBTAIN HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____ Contact #: _____

OBTAIN RECORDS FROM (required):	RELEASE RECORDS TO:
Name: _____	Arvada Vision & Eye Clinic
Address: _____	5801 Olde Wadsworth Blvd
_____ City: _____	Arvada, CO 80003
State: _____ Zip Code: _____	303-422-3817 Phone
Phone: _____ Fax:_ _____	303-423-6317 Fax

We are requesting the most recent two years of records unless otherwise specified.

_____

_____

I hereby authorize the Arvada Vision & Eye Clinic, P.C. to obtain the specified information as stated in this authorization. I understand that the information in my health record may include information relating to sexually transmitted diseases, HIV/AIDS, mental health and drug or alcohol abuse. We will not include records from other doctors' offices. I hereby release the Arvada Vision & Eye Clinic, P.C. and its employees from any and all liability that may arise from the release of information as I have directed. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Without my express revocation, the authorization will automatically expire one year from the date of signature.

Patient Signature: _____ Date Signed:_____

Parent/Guardian Signature: _____ Date Signed: _____