AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

TO

Edmonds, Husz, & Pemberton Eye Center, PC
4730 E. Pima St
Tucson, AZ 85712
(t) (520) 795-3956 (f) (520) 318-3431

Date Requested: _____

Patient's Name (please print) _____

Patients Date of Birth: _____

Patients Address: _____

_____

Patient's Phone Number: _____

Name, Address, Phone and Fax Number of Doctor's office supplying records:

_____

_____

_____

_____

_____

I authorize the professional office listed above to release my records. Please forward my mail or fax to the office of Edmonds, Husz, & Pemberton Eye Center.

Signature of patient, parent, or guardian: _____