

Alvernon Optical, Inc. / Casas Adobes Optical, Inc.

440 N. Alvernon
Tucson, AZ 85711
(520) 327-6211

4747 E. Sunrise Dr.
Tucson, AZ 85718
(520) 299-4000

7125 E. Tanque Verde
Tucson, AZ 85715
(520) 296-4157

2820 N. Campbell Ave.
Tucson, AZ 85719
(520) 323-3937

6987 N. Oracle Rd.
Tucson, AZ 85704
(520) 297-2501

230 W. Continental Rd., Ste 408
Green Valley, AZ 85622
(520) 625-5657

AUTHORIZATION TO RELEASE VISION RECORDS

TO: _____

I authorize and request release of my records ***from:***

- | | | |
|---|---|---|
| <input type="checkbox"/> Paul Cinalli, OD | <input type="checkbox"/> James J. Murphy, OD | <input type="checkbox"/> David Tetrault, OD |
| <input type="checkbox"/> Paula C. Peterson, OD | <input type="checkbox"/> Theresa Setlock, OD | |
| <input type="checkbox"/> Laura B. Schillig, OD | <input type="checkbox"/> Sharon K. Peterson, OD | |
| <input type="checkbox"/> Alvernon Optical, Inc. | <input type="checkbox"/> Casas Adobes, Inc. | <input type="checkbox"/> _____ |

I authorize and request release of my records ***to:***

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| <input type="checkbox"/> Laura B. Schillig, OD | <input type="checkbox"/> Sharon K. Peterson, OD | |
| <input type="checkbox"/> Alvernon Optical, Inc. | <input type="checkbox"/> Casas Adobes, Inc. | <input type="checkbox"/> _____ |

Please release my records as indicated below:

- My complete record or last _____ years of history
- Last office visit notes
- Last glasses or contact lens Rx
- Other _____

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Please print name: _____

Relationship: _____

Witness's Signature _____ Date: _____

Witness's Printed Name _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance thereon. The consent will expire 1 year from date of signature. Any information which is protected under Federal confidentiality rule (42 CFR Part 2) will be treated as specified by such rules.