Cimarron Vision Therapy
6602 E. Carondelet Dr. Tucson, AZ 85715
Ph (520) 886-8800 ● Fax (520) 886-8805
www.cimarronfamilyvision.net ● visiontherapy@live.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: ____ Date of Birth: ____________________________

Previous Name: ____Phone number: ___________________________

Address: ____

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I request and authorize ____ to release healthcare information of the patient listed above to:

Cimarron Family Vision Center
6602 E Carondelet Dr.
Tucson, AZ 85710
Phone (520) 886-8800 ● Fax (520) 886-8805

This authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates: ___________________________
  ____
- ☐ All healthcare information
- ☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq,. includes herpes, herpes simplex, human papilloma virus, warts, genital warts, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

- ☐ I authorize the release of my STD, HIV/AIDS testing, whether negative or positive, to the person(s) listed above.
- ☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

____ ______________________________

Signature (Patient, Legal Guardian, Personal Representative) **Date**

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Print Name and Relationship if not patient