**RECORDS RELEASE MEDICAL AUTHORIZATION**

Patient Name:

Address: City:

State: Zip: Phone:

Which records are needed:

Reason for Transfer/Request:

I, the undersigned, do hereby authorize and direct you to:

[ ] Furnish records **TO** Riviera Opticare, Inc.

[ ] Release records **FROM** Riviera Opticare, Inc.

**I UNDERSTAND THAT RIVIERA OPTICARE, INC. DOES NOT RELEASE COPIES OF RECORDS RECEIVED FROM OTHER HEALTH CARE PROVIDERS. PLEASE CONTACT THOSE PROVIDERS FOR ANY OTHER RECORDS.**

**PROVIDER INFORMATION:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Check how records are to be received: Mail \_\_\_\_\_\_\_\_\_\_ Pick-Up \_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_

**Medical Records Request Fees:**

* *NO* *CHARGE* for Any Records that are to be released for the purpose of continuation of care to a designated physician
* *$25.00* May be charged for Any Records that are to be released for Insurance Company Review, Personal Use, or any other reason not listed

Riviera Opticare, Inc

8752 E. Shea Blvd. Ste. 125

Scottsdale, Az 85260

Phone: (480) 991-6432 Fax: (480) 991-2143

***I understand that my request will be processed within the time frames set forth by state law or within 30 days, whichever is less. I understand that I may be responsible for cost for copies.***

*\*A Copy of this authorization is as valid as an original and will expire 6 months from the date below.\**

Print Name:

Signature: Date:

Witness: Date: