RIVIERA OPTICARE INC.

RECORDS RELEASE MEDICAL AUTHORIZATION

Patient Name: ____ DOB: ___________________________

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. from: ___(Listed Below)___

[ ] Release records **FROM** Riviera Opticare, Inc. to: ___(Listed Below)___

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

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
555 N Gilbert Rd, Suite 101
Mesa, AZ 85203
Ph: (480) 827-9184 F: (480) 461-0703

Riviera Opticare, Inc
8752 E. Shea Blvd, Suite 125
Scottsdale, AZ 85260
Ph: (480) 991-6432 F: (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 __________________________