Central Valley Eye Medical Group, Inc.

Stockton Phone: (209) 952-3700 Stockton Fax: (209) 952-0553 36 W. Yokuts Ave. Suite #1, Stockton, CA 95207

Manteca Phone: (209) 239-5303 Manteca Fax: (209) 239-0090 200 Cottage Ave. Suite #102, Manteca, CA 95336

Modesto Phone: (209) 579-8800 Modesto Fax: (209) 579-1407 1334 Nelson Ave. Modesto, CA 95355

Authorization to Request My Health Information

Patient Name:				
Date of birth:				
My authorization				
Central Valley Eye Medical Group, I	nc. may request the	e following health card	e information	
☐ All my health information maintained	l by you			
☐ My health information relating to the	following treatment	t or condition:		
☐ My health information for the date (s)):			
□ Other:				
You may request this health informat	tion from:			
Name(or title)/organization or if self, w	rite self:			
Address:	City	State:	Zip	
Reason(s) for this authorization (che	ck all that apply):			
□ at my request				
□ other				
(specify)				
Patient or legally authorized individual signa	ature		Date	
Patient is unable to sign because of:				
		or patient's inability to sign		
Printed name if signed on behalf of the patient	•	Relationship & Authority (parent, legal guardian, personal representative, etc.)		