

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Telephone: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Request: \_\_\_\_\_

I hereby authorize release of any medical information between the following parties, with no limitations. This authorization includes any information concerning treatment for mental illness, alcohol and/or drug abuse and related conditions, HIV test results and/or AIDS or AIDS related conditions.

Release Records From: Retina Physicians & Surgeons, Inc  
89 Sylvania Drive, 2nd Floor  
Dayton, Ohio 45440  
937-427-8900  
937-427-1710 Fax

Send Records To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I \_\_\_ do / \_\_\_ do not authorize this information to be faxed. Fax number: \_\_\_\_\_

This information is being disclosed for the purpose of:

\_\_\_ Continuing health care                      \_\_\_ Specialist referral  
\_\_\_ Other (please specify) \_\_\_\_\_

\_\_\_ Complete Medical Record to be Disclosed

\_\_\_ Only Health Information from the following dates From: \_\_\_\_\_ To: \_\_\_\_\_

A photocopy of this authorization is to be accepted the same as the original. I understand that I have the right to withdraw this request in writing at anytime (see Notice of Privacy Practices), except in the case where the authorized release has already been carried out. Once the office discloses health information, the person or organization that receives it may re-disclose it and those later disclosures may not be protected by law. Unless otherwise indicated, this authorization will expire ninety (90) days from the date signed below and covers only the dates specified above.

I understand that there may be a fee for preparing and furnishing this information.

I have read the above release and authorize the above facility to release the information specified.

\_\_\_\_\_  
Signature of Patient or Legal Representative      Relationship to Patient      Date