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