AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION
RETINA SERVICES, LTD.

The undersigned hereby authorizes the release of medical information as follows:

Patient Name____Phone ____________________
First Middle Last

Address____

City/State/Zip ____

Birth Date______________________ Social Security Number______________________

I authorize:

____
Physician/Clinic Name

____
Address

To release information regarding my medical care and treatment to:

____
Physician/Clinic Name

____
Address

Information to be released:

☐ All records including medical history or diagnostic and therapeutic information.

☐ Information confined to the following specified information:

____

____

Special Note: I understand that the information disclosed may contain matter that is protected by Federal and State Laws, including information which may relate to ALCOHOL AND DRUG ABUSE, PSYCHIATRIC DISORDERS AND TREATMENT, AIDS, and/or OTHER SEXUALLY TRANSMITTED DISEASES. I specifically consent to release and disclosure of this information, including transmission of my medical records via a facsimile (FAX) machine. Subsequent transfer of the records or the disclosure of their content is prohibited without my specific consent.

____ ____________________
Signature of patient or authorized guardian Date Signed

Relationship/Status if signed by anyone other than the patient____________________

This authorization expires 90 days after the date it is signed