AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION RETINA SERVICES, LTD.

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

Patient Name	Phone			
Address		Middle		
City/State/Zip_				
Birth Date			Social Secu	urity Number
I authorize:				
	N	Phys	ician/Clinic	Name
•			Add	lress
To release infor	mation r	egarding m	y medical c	are and treatment to:
		Phys	ician/Clinic	Name
			Address	
Information to l	oe releas	ed:	Address	
All record	s includi	ng medical	history or d	liagnostic and therapeutic information
				ecified information:
is protected by I ALCOHOL ANI AIDS, and/or consent to relea medical records	Federal a D DRUG OTHER ase and o via a fa	and State La G ABUSE, Pa SEXUALL disclosure o ccsimile (FA	aws, includi SYCHIATRI Y TRANSN f this inforn X) machine	n disclosed may contain matter that ng information which may relate to C DISORDERS AND TREATMENT, MITTED DISEASES. I specifically nation, including transmission of my. Subsequent transfer of the records without my specific consent.
Signature of pat Relationship/St	atus if s	igned by ar	yone other	Date Signed than the patient fter the date it is signed