RETINA CONSULTANTS, P.C.

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AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____
(Please Print)

I authorize: _____
Doctor or Hospital

To release all of my medical records, including any information relating to medical, psychiatric, drug and/or alcohol and HIV related treatment to:

_____
Address

If I specify a period of records to be released, I will do so below; otherwise I would like all my medical records to be released.

From _____ to _____

This authorization may be revoked by me at any time, except to the extent that action has been taken thereon.

Name: _____ Date: _____

Address: _____

Signature: _____ Witness: _____
(If relative or under 18, please state relationship to patient.)

The following are a part of the Release Form to the extent applicable:

HIV Related Information: "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is not sufficient for this purpose."

www.RetinaCT.com

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Hartford, CT 06106
Phone: (860) 525-3900
Fax: (860) 241-8112

43 Woodland Street, Suite 100
Hartford, CT 06105
Phone: (860) 527-9020
Fax: (860) 527-4320

191 Main Street
Manchester, CT 06042
Phone: (860) 646-7704
Fax: (860) 647-7340

399 Farmington Ave.
Farmington, CT 06032
Phone: (860) 409-7800
Fax: (860) 409-7803

9 Cranbrook Blvd., First Floor
Enfield, CT 06082
Phone: (860) 741-4300
Fax: (860) 741-4302

80 Shunpike Road, Suite 103
Cromwell, CT 06416
Phone: (860) 788-6569
Fax: (860) 788-7075