



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:

(Doctor or Hospital and 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 years of age, 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."

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