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THE RETINA INSTITUTE

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Authorization to Obtain/Release Information

Patient Name: _____ Date of Birth: _____

Where are the records going? (DO NOT LEAVE BLANK)

Provider _____

Address _____

City, State, Zip _____

Telephone _____

Fax _____

Who is sending the records? (DO NOT LEAVE BLANK)

Provider _____

Address _____

City, State, Zip _____

Telephone _____

Fax _____

What records are to be sent?

____ All medical records (please note that this release includes information regarding Alcohol/Substance Abuse, Psychiatric/Mental Health Information and HIV Information).

____ Limited medical records

- ☐ Laboratory Reports
- ☐ HIV Information
- ☐ Copy of Retinal Photos
- ☐ Pathology Reports
- ☐ Information Related to Eye Condition Only (Exam Letters)
- ☐ Itemized Statement

For the time period: From*:_____ (Mo/Day/Year) To*: _____ (Mo/Day/Year)

For the following purpose: _____

I have signed this authorization and permit it to be valid **only** for a period of two years from the date shown below. I understand that this Authorization can be revoked in writing to The Retina Institute's Privacy Officer at the administrative address listed above. Any such revocation will not apply with respect to information already disclosed pursuant to this Authorization. The Retina Institute provides records to patients through the mail or in person, but never over a fax machine.

I understand that I am not required to sign this Authorization and that my health care treatment, payment or enrollment or eligibility for benefits will not be effected by my refusal to sign this Authorization. I understand that information released to third parties pursuant to this Authorization may be re-disclosed and may no longer be subject to protection under law.

_____ _____
(Signature of Patient, Trustee, Parent or Guardian)* (Today's Date)*

_____
(Relationship to Patient)

_____ _____
(Telephone Number)* (Witness)

Return to: healthinfoservices@rc-stl.com Fax: 314-968-3375

*(*Required Field)*