



Administrative Office: 1600 S. BRENTWOOD BLVD. / SUITE 800 / ST. LOUIS, MISSOURI 63144 / 314.367.1181 or 800.888.0011 / fax: 314-968-3375 / TRI-STL.com

Authorization to Obtain Information

I, _____ hereby authorize
(Patient Name)
_____ to release a copy
(Provider Name)
_____ of the following:
(Provider Address)

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

_____ Limited medical records,

- | | |
|---|---|
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> HIV Information | <input type="checkbox"/> Information Related to Eye Condition Only (Exam Letters) |
| <input type="checkbox"/> Copy of Retinal Photos | <input type="checkbox"/> Itemized Statement |

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

To: *The Retina Institute, Health Information Services*
1600 S. Brentwood Blvd., Suite 800, St. Louis, MO 63144

For the following purpose: _____

I have signed this authorization and permit it to be valid **only** for a period of ninety (90) days 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)

(Patient's Date of Birth)

(Relationship to Patient)

(Today's Date)

(Telephone Number)

(Witness)