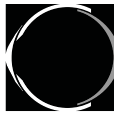
Kevin J. Blinder, MD
Sabin Dang, MD
Nicholas E. Engelbrecht, MD
M. Gilbert Grand, MD
Daniel P. Joseph, MD, PhD



THE RETINA INSTITUTE

Thomas K. Krummenacher, MD
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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 Release Information

I, ______________________________ (Patient Name) hereby authorize The Retina Institute Health Information Services to release, use or disclose the following:

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

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

To: (Recipient of records): ______________________________
(Name)

____
(Address)

____
(City, State, Zip Code)

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)