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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient: (Please Print): _____Date of Birth: _____

I authorize: (Name of Hospital/Health Care Provider)

_____

Address: _____State: _____ Zip Code: _____

Phone: _____ Fax: _____

To release medical records to: (Name of Hospital/Health care provider/Clinic/Person)

_____

Address: _____State: _____ Zip Code: _____

Phone: _____ Fax: _____

By initialing the space below, I specifically authorize the release of the following medical records, if such records exist:

_____ Please send ALL Medical Records (limited to five year history)

*Retina Consultants reserves the right to charge for the cost of copying the records

_____ Most Recent two year history

_____ Other **(Specify)**_____

*Federal Regulation 42 CFR Part 2 requires description of how much and what kind of information is to be disclosed. I understand that by initialing below I am specifically authorizing the release of information relating to:

* HIV/AIDS- related records _____ *Genetic testing information _____

*Mental Health information _____ *Drug/alcohol diagnosis, treatment or referral info _____

This authorization can be revoked at any time. Unless revoked earlier, this consent will expire 180 days from the date of signing.

SIGNATURE OF PATIENT: DATE:

SIGNATURE OF PERSON AUTHORIZED BY LAW: DATE: