Taylor Retina Center

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MEDICAL RECORDS REQUEST

Patient Name: _____ **DOB :**_____ **Date:** _____

I authorize: _____

at _____

To release to: _____

at: _____

the following medical information which may/may not include:

- ☐ Dictated Summary/Office Notes
- ☐ Fundus Photos
- ☐ Visual Fields
- ☐ Fluorescein Angiography
- ☐ Other: _____
- ☐ Operative Reports
- ☐ CT Scan
- ☐ Lab Results
- ☐ MRI
- ☐ EKG

☐ I do ☐ I do not authorize release of information related to AIDS or HIV

☐ I do ☐ I do not authorize release of information related to psychiatric care and/or psychological assessment

☐ I do ☐ I do not authorize release of information related to treatment for drug and/or alcohol abuse

I understand that the purpose or need for this disclosure is to:

_____

I understand that this authorization is valid for 90 days from the date signed below and is revocable by me upon written notification at any time. I also understand that further disclosure of this information is prohibited without my prior written consent, unless otherwise permitted by law.

_____

Signature of patient/legal guardian/power of attorney, or authorized person

_____ _____

Relationship to patient **Date**

Patient is: Minor Incompetent Disabled Deceased (circle appropriately)

_____ _____

Signature of witness **Date**