Premier Retina Specialists

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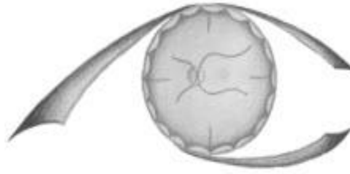

Medical Records Release

Patient Information

Name		**DOB**	
SSN		**Phone#**	
Address		**Appt/Ste**	
City / State		**Zip**	

Please release a complete COPY of my medical records FROM:

Name		**Phone#**	
Address		**City**	
State/Zip		**Fax #**	

Release Records To: (Or) Obtain Records From: (Or) Release Records To Myself:

Name		**Phone#**	
Address		**City**	
State/Zip		**Fax #**	

PLEASE INCLUDE THE FOLLOWING: ***(Charges may apply to Photos and/or Color copies)***

	Fluorescein Angiogram
	Fundus Photos
	Color Copy of OCT
	Lab/Testing Results
	Other:

I understand that this information is for use by myself or the recipient above. It cannot be given to any other individual or agency without my written consent. I also understand that the records may contain information relating to psychiatric or psychological testing, physical abuse, drug or alcohol abuse and HIV/AIDS test results. This authorization is valid only 90 day from the date signed and I may revoke it at any time.

Patient Signature or Legal Guardian	**Date**
Printed Guardian Name:	

v4.2015

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