CHARLES
RETINA
INSTITUTE

Patient Name: _____

Date of Birth: _____ Phone: _____

☐ Please release my medical records ***from*** Charles Retina Institute to:

☐ Please release my medical records ***to*** Charles Retina Institute from:

Name of Company/Doctor/Person _____

Phone#: _____ **Fax**#:_____

Or **Address**: _____

City: _____State: _____Zip Code: _____

☐ Will pick up in office

Purpose of this disclosure (Please select the following):

☐ Healthcare Provider
☐ FMLA/APS Form/Letter
☐ Personal Records
☐ Other (Please Specify) _____

_____

☐ All healthcare information

☐ Other _____
(Specify)

_____

I understand that I have the right to revoke this authorization in writing, at any time, except where uses or disclosures have already been made upon my original permission. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire 1 year from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards.

_____ _____
Signature of patient or patient's authorized representative Date

_____
Print Guardian Name

Received on: _____ **Received By:** _____

www.charlesretina.com
FAX: 901-761-0727
PLEASE ALLOW SEVEN TO TEN BUSINESS DAYS FOR COMPLETION OF YOUR REQUEST.