Patient Request for Release of Medical Information

Patient Name: _____
(Last Name, First Name, Middle Initial)

Date of Birth: _____ Social Security Number: _____

Records Released From:

_____
(Name of Doctor/Clinic/Program)

_____
(Street Address)

_____
(City) (State) (ZIP)

_____
(Phone if known) (Fax if known)

Records Released To:

_____
(Name of Doctor/Clinic/Program)

_____
(Street Address)

_____
(City) (State) (ZIP)

_____
(Phone if known) (Fax if known)

Type of Information to be released: *(Check all that apply)*

_____Medical History _____ Lab Results _____Surgical Reports _____Doctor's Notes _____ ALL

** Fluorescein Angiogram, Fundus, and OCT Reports are included in Doctor's Notes. If you require a copy of the actual films/readings, please check here and the most recent set will be copied and sent. ___FA/Fundus ___OCT

Purpose of release: ___Continuing Care __Insurance Application / Claim __Worker's Comp

_____Personal / Other_____

Special Instructions: _____Mail _____Pick Up Requestor ID Verified: _____ Verified by: _____

I authorize the above listed physicians, clinics, and/or hospitals to release information as described above. I understand that this authorization is voluntary. I may revoke this authorization by completing *Retina & Vitreous Consultants of Wisconsin Revocation of Authorization* form so long as the company has not yet relied upon and/or acted upon my authorization. I understand that I do not have the right to revoke this authorization if it was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim under the policy. I understand that information used or disclosed as a result of this may no longer be protected by federal privacy laws and may be further used or re-disclosed by persons or organizations receiving it.

I understand that if I agree, Retina & Vitreous Consultants of Wisconsin may choose to provide a summary of the requested protected health information and may charge a fee for this. Retina & Vitreous Consultants of Wisconsin has the right to impose a reasonable, cost-based fee for copying, postage and preparation of records associated with fulfilling this request.

This authorization expires on ____/____/____ (MM/DD/YY). If I do not indicate a date, this will expire one year from the date of my signature below.

_____ _____
Signature of Patient Date

_____ _____
And when applicable signature of: Date

____ Parent of Legal Guardian ____ Next of Kin of Deceased ____ Power of Attorney