RETINA & VITREOUS CONSULTANTS OF WI, LTD

Additional Release(s) of Medical Information and Medical Records to Designated Persons.

In addition to the above consents for release of information, I authorize Retina & Vitreous Consultants of Wisconsin, Ltd., to release records and information regarding my health to the designated person(s) listed below. I understand the additional release(s) may be revoked at any time by providing my written revocation.

Person To Release to: (Name) ____

____

Relationship (Optional) Phone Number with Area Code (Optional)

Type of Information to be released: (Check All That Apply)

___ Medical History ____ Lab Reports ____ Surgical Reports ____ Test Results
___ Doctor's notes ____ Billing/Statement Information ____ All of the Above

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.

Person To Release to: (Name) ____

____

Relationship (Optional) Phone Number with Area Code (Optional)

Type of Information to be released: (Check All That Apply)

___ Medical History ____ Lab Reports ____ Surgical Reports ____ Test Results
___ Doctor's notes ____ Billing/Statement Information ____ All of the Above

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, Legal Guardian or Power of Attorney Date

You may request additional release(s) of medical information and medical 1records forms from the front desk.

Witnessed by: _________