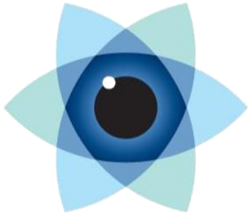

RETINA HEALTH INSTITUTE S.C.

Vision Redefined
1530 N Randall Road, Suite 202, Elgin, IL, 60123
847-488-1030 (Office)   847-488-0677 (Fax)
www.retinahealthinstitute.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO RETINA HEALTH INSTITUTE S.C.

TODAY'S DATE _ _ / _ _ / _ _ _ _

PATIENT NAME & ADDRESS	**DOB** **MRN**

I hereby authorize Retina Health Institute, S.C. to obtain from:

DOCTOR OR HOSPITAL	**FAX #**
ADDRESS	

any information regarding, including the diagnosis, treatment, or examination rendered to me during the period from:

_ _ / _ _ / _ _ _ _ to _ _ / _ _ / _ _ _ _

CONFIDENTIALITY POLICY (PLEASE READ BEFORE SIGNING)

Medical records are maintained to serve the patient and the healthcare providers in accordance with legal and regulatory requirements. The information contained in medical records is considered highly confidential. All patient care information shall be regarded as confidential and available only to authorized users. The term "medical records" includes any protected health information (PHI) which includes test results, any medical reports, the medical record itself, claim files, and any correspondence relating to the care of a patient. Any disclosure of my protected health information to a different name, class of person, address or fax number will require a separate authorization. I have the right to revoke this authorization in writing, except to the extent that action has already been taken in reliance on this authorization, or if applicable, during a contestability period. In order for the revocation of this authorization to be effective, the above name(s) or class of person(s) must receive the revocation in writing. This authorization shall expire one year from the date signed or on the following date: _ _ / _ _ / _ _ _. After one year or this date (which ever comes sooner), a new authorization form is needed for continual disclosure of my PHI.

I fully understand and accept the terms of this authorization. A copy of this authorization is valid as an original.

SIGNATURE
(PATIENT or AUTHORIZED HIPAA CONTACT)

PRINT NAME

v1.0