ILLINOIS RETINA ASSOCIATES, S.C.
THE RETINA CENTER

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION / RECORDS RELEASE

Patient Name: _____ DOB: _____ Request Date: _____ ☐ Verbal Request

Address/City/State/ZIP: _____

I hereby authorize Illinois Retina Associates/The Retina Center, to disclose the following information from my health records covering the period(s) of healthcare:

From: _____ To: _____ □ All Records

INFORMATION FOR RELEASE:

☐ Complete Health Records ☐ History & Physical Exam ☐ F/A Prints ☐ F/A Reports

☐ Consultation Reports ☐ X-Ray Reports ☐ Fundus Photo Image

☐ Discharge Summary ☐ Progress Notes ☐ Lab Tests ☐ OCT Image

Other: (Please specify)

_____

I understand that this will include information relating to the following if applicable:

- Acquired Immunodeficiency Syndrome (AIDS) - Human Immunodeficiency Virus (HIV)
- Psychiatric Care - Treatment for Alcohol and/or Drug Abuse

This information is to be disclosed to: ☐ Patient ☐ Other (See Below)

Name _____

Address/City/State/ZIP: _____ Phone ( ) _____

☐ Pick up ☐Mail ☐ Fax #_____ ☐ Email _____

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. Because e-mail is an insecure means of communication, and may be viewed by others, I waive Illinois Retina Associates, S.C., of any responsibility due to unauthorized disclosure. I further understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked this authorization will expire on the following:

☐ 30 days ☐ 1 year ☐ After request is fulfilled ☐ Date specified by patient _____

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for proper disclosure of the above information to the extent indicated and authorized herein.

_____

Patient Signature Date

_____

or Legal/Patient Representative (Relationship to Patient) Date

_____

Witness Signature or Illinois Retina staff obtaining verbal authorization Date

☐ Uploaded to R Drive