ILLINOIS RETINA ASSOCIATES/ THE RETINA CENTER
AUTHORIZATION FOR ACCESS TO PROTECTED HEALTH INFORMATION-RECORDS RELEASE

Patient Name: _____ DOB: _____ Request Date: _____ ☐ Verbal Request
Address/City/State/ZIP: _____
Daytime Phone #:(___) _____ Email address: _____

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_____

If you request records to be sent via email, we cannot guarantee that they will be secure or confidential during transit or in the email account with which they are sent. In addition, Illinois Retina Associates assumes no responsibility for the security or confidentiality of records provided to a third party at your request. I understand that Illinois Retina Associates may charge a fee for the costs of copying, mailing, or other supplies associated with this request. I further understand that Illinois Retina Associates may, under applicable law, deny my request to access my medical records in certain limited circumstances. In some cases, if I am denied access to my medical information, I may request that the denial be reviewed, in which case a licensed health care professional chosen by Illinois Retina Associates will review my request and the denial. The person conducting the review will not be the person who initially denied the request. Illinois Retina Associates will comply with the outcome of the review. 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