



RETINA ASSOCIATES OF FLORIDA

Diseases & Surgery of the Retina & Macula

Ivan J. Suñer M.D. | Marc C. Peden M.D.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ DOB: _____, hereby authorize Retina Associates of Florida, LLC., to:

release _____ or obtain _____ (please check one) all of the following medical information*

- All records
- Laboratory/pathology records
- X-ray/radiology records
- Other (Describe specifically) _____

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Name: _____	Name: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

for the purpose of _____

I understand that this consent is revocable upon written notice to the center, except to the extent that action by the center has already taken place by this authorization. Retina Associates of Florida is released from all legal liability that may arise from the release of the information requested.

Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulation (42CFR, Part 2) prohibits making any further disclosure of the information without the specific written authorization of the undersigned, or as otherwise permitted by such regulations.

Date Patient Signature

Date of Birth (Patient) Parent, Legal Guardian or Authorized Representative

FOR OFFICE USE ONLY

Specific records released: _____

Mailed _____ Faxed _____ Date _____ By: _____