RETINA ASSOCIATES OF FLORIDA
Diseases & Surgery of the Retina & Macula
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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 herby 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

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FOR OFFICE USE ONLY

Specific records released: _____

Mailed_____ Faxed_____ Date_____ By: _____