Retina Consultants of Michigan

29201 Telegraph Rd., Suite 606
Southfield, Michigan 48034
248-356-8610 • 248-356- 6473

27301 Schoenherr, Suite 101
Warren, Michigan 48088
586-756-3800 • Fax 586-756-9756

50182 Schoenherr
Shelby Twp., Michigan 48315
586-522-4256 • 586-501-3235

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT: _____ DATE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY: _____

The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

RELEASE INFORMATION FROM: _____

ADDRESS: _____

RELEASE INFORMATION TO: _____

ADDRESS: _____

The following information to be released:

_____**ALL MEDICAL RECORDS**

_____**FLUORESCEIN ANGIOGRAPHY (ACTUAL PICTURES NOT REPORT)**

_____**FUNDUS PHOTO (ACTUAL PICTURES NOT REPORT)**

_____**OTHER**

I UNDERSTAND THAT THE INFORMATION USED OR DISCLOSED MAY BE SUBJECT TO RE-DISCLOSURE BY THE PERSON OR CLASS OF PERSONS OR FACILITY RECEIVING IT, AND THEN WOULD NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS. I MAY REVOKE THIS AUTHORIZATION BY NOTIFYING RETINA CONSULTANTS OF MICHIGAN IN WRITING OF MY DESIRE TO REVOKE MY RELEASE. I UNDERSTAND THAT ANY ACTION ALREADY TAKEN IN RELIANCE ON THIS AUTHORIZATION CANNOT BE REVERSED, AND MY REVOCATION WILL NOT AFFECT THOSE ACTIONS. I UNDERSTAND THAT THE MEDICAL PROVIDER TO WHOM THIS AUTHORIZATION IS FURNISHED MAY NOT CONDITION ITS TREATMENT OF ME ON WHETHER OR NOT I SIGN THE AUTHORIZATION.

THIS AUTHORIZATION EXPIRES ON _____20_____, OR UPON OCCURRENCE OF THE FOLLOWING EVENT THAT RELATES TO ME OR TO THE PURPOSE OF THE INTENDED USE OR DISCLOSURE OF INFORMATION ABOUT ME. A PHOTOCOPY WILL HAVE THE SAME AUTHORITY AS THE ORIGINAL.

_____ _____

Signature of Patient Date of Signature

OR if Applicable

_____ _____

Signature of Guardian or Personal Representative Date of Signature

_____ _____

Description of Guardian/Personal Representatives Authority for the Individual