Diseases and Surgery of the Retina, Vitreous and Macula

Peter Condax MD FACS *George Condax MD FACS*

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____

Phone#: _____ SSN: _____

I. I hereby authorize the release of medical information.
Send Medical Information to:

_____
Name of Person or Entity to Receive Information

_____
Title {Physician, Attorney}

_____
Street Address

_____
City, State & Zip Code

_____ _____
Phone Number Fax Number (if listed, authorization to Fax record)

II. Reason for Request: {Check Box}
☐ For payment/insurance
☐ Transfer to another physician
☐ I am seeking disability benefits
☐ Other: _____

III. Records Requested:
☐ All Medical Records ☐ Specific records from _____ to_____ ☐ Other _____

IV. I understand that my medical records are protected under state and federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections (including testing or treatment for HIV/AIDS), and diagnosis of mental illness or psychiatric care cannot be released without my written consent. **Please initial below if you DO NOT want any of the following records released. All applicable records will be released if nothing is marked.**

____Drug and/or alcohol abuse, diagnosis or treatment ____HIV/AIDS testing and/or treatment
____Confirmed STI test results and/or treatment ____Psychiatric care and/or mental illness

V. I understand that my medical records contain information relating to my diagnosis and treatment, and I authorize the release of all such information listed above. I further understand that I may refuse authorization to disclose all or some of the above health care information, but that my refusal may result in improper diagnosis or treatment, denial of coverage of a claim for health benefits or other insurance, or other adverse consequences.

VI. This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 6 months.

_____ _____
Patient Signature (or guardian, if minor child) Date