



Diseases and Surgery of the Retina, Vitreous and Macula

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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

II. Reason for Request: {Check Box}

☐ For payment/insurance

☐ Transfer to another physician

☐ I am seeking disability benefits

☐ Other: _____

Phone Number

Fax Number (if listed, authorization to Fax record)

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 1 year.

Patient Signature (or guardian, if minor child)

Date

Fax completed form to: 718-539-4021 or mail to: 170-17 Northern Blvd, Flushing NY 11358