Retina-Vitreous Associates Medical Group

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO ANOTHER PHYSICIAN/FACILITY

TODAY'S DATE _ _ / _ _ / _ _ _ _

PATIENT NAME	DOB
ACCOUNT #	**AGE**

I hereby authorize:

☐ David S. Boyer, MD	☐ Richard H. Roe, MD, MHS
☐ Roger L. Novack, MD, PhD, FACS	☐ Pouya N. Dayani, MD
☐ Thomas G. Chu, MD, PhD	☐ David S. Liao, MD, PhD
☐ Firas M. Rahhal, MD	☐ Alexander C. Walsh, MD
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To release to:

DOCTOR OR HOSPITAL	FAX #
ADDRESS	

any information, including the diagnosis, treatment, or examination rendered to me during the period from:

__ __ / __ __ / __ __ __ __ to __ __ / __ __ / __ __ __ __

CONFIDENTIALITY POLICY (PLEASE READ BEFORE SIGNING)

Medical records are maintained to serve the patient and the healthcare providers in accordance with legal and regulatory requirements. The information contained in medical records is considered highly confidential. All patient care information shall be regarded as confidential and available only to authorized users. The term "medical records" includes any test result, any medical reports, the medical record itself, claim files, and any correspondence relating to the care of a patient.

A copy of this authorization is valid as an original.

I have the right to receive a copy of this authorization. The copy is for me to keep.

SIGNATURE (PATIENT OR NEAREST RELATIVE)
IF NEAREST RELATIVE, PLEASE STATE RELATIONSHIP TO PATIENT
SIGNATURE OF WITNESS