

THE RETINA INSTITUTE

AUTHORIZATION TO RELEASE INFORMATION

I, _____ hereby authorize
(Patient Name)

The Retina Institute Medical Records Department to release, use of disclose the following:

_____ All medical records (Please note that this release includes information regarding:
Alcohol/Substance Abuse, Psychiatric/Mental Health Information, and HIV Information.)

Limited Release

- | | |
|---|--|
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> HIV Information | <input type="checkbox"/> Information Related to Eye Condition Only |
| <input type="checkbox"/> Copy of Retinal Photos | <input type="checkbox"/> Itemized Statement |

for the time period FROM: _____ TO: _____
(Mo/Day/Yr) (Mo/Day/Yr)

To (Recipient): _____
(Name)

(Address)

(City, State, Zip)

For the following purpose: _____

I have signed this Authorization on _____ and permit it to be valid only for a
(Mo/Day/Yr)
period of ninety (90) days from the date shown above. I understand that I may revoke this
Authorization at any time by writing to:

**The Retina Institute's Privacy Officer
1600 S. Brentwood Blvd., Suite 800
St. Louis, MO 63144**

Any such revocation will not apply with respect to information already disclosed pursuant to this
Authorization.

I understand that I am not required to sign this Authorization and that my health care
treatment, payment or enrollment or eligibility for benefits will not be affected by my refusal to sign this
Authorization.

I understand that information release to third parties pursuant to this Authorization may be re-dis-
closed and may no longer be subject to protection under law.

The Retina Institute provides records to patients through mail or in person, but not over a fax machine.

(Signature of Patient, Trustee, Parent or Guardian)

(Patient DOB)

(Pt. Social Security No.)

(Relationship to Patient)

(Telephone Number)

**The Retina Institute Rep/
Witness Signature**