

Retina and Vitreous Consultants of Wisconsin, Ltd.
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Patient Request for Release of Medical Information

Patient Name: _____
(Last Name, First Name, Middle Initial)

Date of Birth: _____ Social Security Number: _____

Records Released From: _____ (Name of Doctor/Clinic/Program)	Records Released to: _____ (Name of Clinic or Class of Persons)
_____ (Street Address)	_____ (Street Address)
_____ (City) (State) (ZIP)	_____ (City) (State) (ZIP)

Type of Information to be released: *(Check all that apply)* _____ Medical History _____ X-Ray
_____ Surgical Reports _____ Lab Results _____ Doctor's Notes _____ ALL

Other: _____

Purpose of release: ___ Continuing Care ___ Insurance Application / Claim ___ Worker's Comp
_____ Personal / Other _____

Special Instructions: _____ Mail _____ Pick Up Requestor ID Verified: _____ Verified by: _____

I authorize the above listed physicians, clinics, and/or hospitals to release information as described above. I understand that this authorization is voluntary. I may revoke this authorization by completing *Retina & Vitreous Consultants of Wisconsin Revocation of Authorization* form so long as the company has not yet relied upon and/or acted upon my authorization. I understand that I do not have the right to revoke this authorization if it was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim under the policy. I understand that information used or disclosed as a result of this may no longer be protected by federal privacy laws and may be further used or re-disclosed by persons or organizations receiving it.

I understand that if I agree, Retina & Vitreous Consultants of Wisconsin may choose to provide a summary of the requested protected health information and may charge a fee for this. Retina & Vitreous Consultants of Wisconsin has the right to impose a reasonable, cost-based fee for copying, postage and preparation of records associated with fulfilling this request.

This authorization expires on ____/____/____ (MM/DD/YY). If I do not indicate a date, this will expire one year from the date of my signature below.

Signature of Patient

Date

And when applicable signature of:

Date

_____ Parent of Legal Guardian _____ Next of Kin of Deceased _____ Power of Attorney