Records Release to Capital Region Retina

Date:

From:

I authorize the above named physician or other medical or medically related facility to release copies of all medical records and medical information for the purpose of updating records to:

Capital Region Retina, PLLC
1365 Washington Ave, Suite 101
Albany, NY 12206
Telephone: 518-437-1111, Fax: 518-435-1114

The information authorized for release is inclusive of the following records for the time period from

(begin date) to (end date) .

Please circle and initial each type of record listed to confirm or deny request:

I (do / do not) authorize the release of diagnostic information and photocopies of the complete records of any and all treatment, advice, medication, test results, or examination rendered to me.

I (do / do not) authorize the release of information regarding communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, and Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC).

I (do / do not) authorize the release of information regarding psychiatric or mental health evaluations.

I (do / do not) authorize the release of information regarding alcohol and drug related conditions.

Please note: Records previously obtained from another physician from other providers could contain information that may be sensitive to you. We do not know whether they contain such sensitive information Furthermore, we have no way of knowing whether previous providers have released a complete copy of the record.

Patient's Signature: Phone Number:

(Parent or guardian must sign if patient is a minor.)

Printed Name: Date of Birth:

Date Signed: