RETINA ASSOCIATES OF ORANGE COUNTY

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Diseases and Surgery of the Retina, Macula and Vitreous

MEDICAL RECORDS RELEASE

Patient Information

Printed Full Name: _____

Address: _____

Date of Birth: _____ Phone Number: _____

I hereby authorize Retina Associates of Orange County (RAOC), or any of its employee or staff to use, request, and disclose health information from the medical record(s) of the named above.

I understand I have the right to revoke the authorization, in writing, at any time by sending such written notification to Retina Associates of Orange County. This authorization is valid until I revoke it in writing.

_____ _____

PATIENT or LEGAL GUARDIAN SIGNATURE DATE

Release of Medical Information

Release Information **To**:

_____

FAX Number :_____ Phone Number:_____

Address:_____

Request Information **From**:

_____

FAX Number :_____ Phone Number:_____

Date of Service: _____

Type of medical information:_____

_____

Reason for Disclosure:_____

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