



Authorization for the Release of Medical Information

_____ (patient's name) _____ (date of birth)
Alliance Retina to furnish records and medical information to (name and address of physician)

All information about the care and treatment of the above-named patient may be released, including but not limited to information about general medical care, out-patient treatment with a psychotherapist, and substance abuse/chemical dependency treatment, with the following exceptions: _____

PLEASE NOTE: For the release of specially-protected medical information (e.g., federal- or state-assisted drug and/or alcohol abuse treatment records, and HIV test results), the box below must be completed by the patient or his/her representative.

Disclosure of the records/information may be used **only** for the following purposes: _____

I have been advised of my right to receive a copy of this form.

Print Name: _____ Date: _____

Signature: _____ This authorization expires on: _____

*** If form is not signed by patient, indicate relationship of signer:**

- Parent or guardian of minor patient (for care for which the minor was not permitted to consent)
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient
- Spouse or person financially responsible (solely when information is needed to process application for dependent health care coverage)

Special Authorization for the Release of Specially-Protected Medical Information	
I authorize release to the above-listed recipient the following records concerning the patient designated above.	
_____ (Initial) Drugs and/or alcohol abuse records of federal- or state-assisted programs.	
_____ (Initial) HIV test results.	_____ (Initial) Genetic test results.
Print name: _____	
Signature: _____	Date: _____
Patient or Authorized Representative	

Please allow 5 business days to process medical record requests. Send all requests to: