KIM-BINH MAI, MD
VITREORETINAL SURGERY & DISEASES

Authorization for the Release of Medical Information

_____ *(patient's name)* _____ *(date of birth)*
authorizes _____
_____ *(name and address of physician)*
to furnish my records and medical information to

Alliance Retina of Texas
Phone: 817-617-7678 Fax: 817-617-7681

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

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