

THE RETINA INSTITUTE

AUTHORIZATION TO OBTAIN INFORMATION

I, _____ hereby authorize
(Patient Name)
_____ to release a copy
(Provider Name)
_____ of the following:
(Provider Address)

_____ All medical records (Please note that this release includes information regarding:
Alcohol/Substance Abuse, Psychiatric/Mental Health Information, and HIV Information.)

Limited Release

- | | |
|---|--|
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> HIV Information | <input type="checkbox"/> Information Related to Eye Condition Only |
| <input type="checkbox"/> Copy of Retinal Photos | <input type="checkbox"/> Itemized Statement |

for the time period FROM: _____ TO: _____
(Mo/Day/Yr) (Mo/Day/Yr)

To: The Retina Institute, Medical Records Department
1600 S. Brentwood Blvd., Suite 800, St. Louis, MO 63144

For the following purpose: _____

I have signed this Authorization on _____ and permit it to be valid only for a
(Mo/Day/Yr)

period of ninety (90) days from the date shown above. I understand that I may revoke this
Authorization at any time by writing to:

The Retina Institute's Privacy Officer
1600 S. Brentwood Blvd., Suite 800
St. Louis, MO 63144

Any such revocation will not apply with respect to information already disclosed pursuant to this
Authorization.

I understand that I am not required to sign this Authorization and that my health care
treatment, payment or enrollment or eligibility for benefits will not be affected by my refusal to sign this
Authorization.

I understand that information release to third parties pursuant to this Authorization may be re-dis-
closed and may no longer be subject to protection under law.

(Signature of Patient, Trustee, Parent or Guardian)

(Patient DOB)

(Pt. Social Security No.)

(Relationship to Patient)

(Telephone Number)

**The Retina Institute Rep/
Witness Signature**