Premier Retina
Specialists

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Medical Records Release

Patient Information

Name		**DOB**	
SSN		**Phone#**	
Address		**City**	
State/Zip			

Please release a complete COPY of my medical records to:

Myself

Recipient Physician or Facility

Name		**Phone#**	
Address		**City**	
State/Zip		**Fax #**	

PLEASE INCLUDE THE FOLLOWING:

	Fluorescein Angiogram
	Fundus Photos
	Color Copy of OCT
	Lab/Testing Results
	Other:

I understand that this information is for use by myself or the recipient above. It cannot be given to any other individual or agency without my written consent. I also understand that the records may contain information relating to psychiatric or psychological testing, physical abuse, drug or alcohol abuse and HIV/AIDS test results. This authorization is valid only 90 day from the date signed and I may revoke it at any time.

Patient (Legal Guardian) Signature	**Date**

10100 Loop 40, Midland, TX 79702, (432) 617-0181 Office, (432) 569-0656 Fax