CALIFORNIA RETINA CONSULTANTS

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City /State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

CALIFORNIA RETINA CONSULTANTS
Name of Person/Organization Releasing Information

525 E MICHELTORENA STREET SUITE A SANTA BARBARA , CA 93103
Address City / State / Zip

(805)963-1648 Option 4 // (805)881-6102
Phone Number // Fax Number

To Release my Information To:

_____
Name of Person/Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

INFORMATION TO BE RELEASED:

_____ Complete Medical Record
_____ Medical Records for Specific Dates of Service (please list) from_____ to _____
_____ CD/USB with imaging reports ($35 Charge Fee)
_____ PHI to be shared with, Name: _____ Relation to Patient:_____
_____ Other (please list) _____

_____ _____ _____
Printed Name (Patient or Personal Representative) Signature (Patient or Personal Representative) Date

_____
Description of Personal Representative's Authority (attach necessary documentation)

METHOD OF DELIVER:

_____ Mail _____ Secure Email (not available for imaging reports)
_____ Fax _____ Office Pickup

PLEASE SUBMIT FORM VIA:

Email**:** brenda@californiaretina.com Fax**:** (805)881-6102

OFFICE USE:

Received on/by: _____ Date Payment Received: _____
Imaging reports requested: Yes / No Released on/by: _____
Total fee: _____ Released via: mail / fax / secure email / pickup