RETINA CONSULTANTS OF MINNESOTA

Authorization for the Release of Selected Medical Records

Patient Information

Patient Name:		Date of Birth:
Street Address:		
City:	State:	Zip Code:
Phone #	Email:	

I hereby authorize the release of the above-named patient's medical records as specified below from Retina Consultants of Minnesota to the following entity:

☐ **Patient** ☐ **Guardian** ☐ **POA (Legal documentation required)** ☐ **Designated Third Party**

Recipient Information (If different than patient)

Name:	
Phone #	Fax #
Address:	
Email:	

Information to be released:

☐ *Exam Notes From:* ______________ *to* _____________

☐ *Diagnostic Imaging From:* ______________ *to* _____________

☐ *Operative Report From:* ______________ *to* _____________

☐ *Other:* ____

I understand that once health information is disclosed pursuant to this authorization, the information may be subject to redisclosure by the recipient and may no longer be protected by the Federal or State privacy regulations. This authorization shall be effective for 12 months. I understand that I have the right to revoke this authorization, in writing, at any time.

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Signature of Patient/Guardian/POA **Relationship** **Printed Name** **Date**

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Requester Verified by RCM Staff (Signature) **Office** **Printed Name** **Date**

☐ *Verified by Phone* ☐ *Signed in Person* ☐ *Other* _______________