Inland Valley Retina

Medical Associates, Inc.

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RECORDS RELEASE AUTHORIZATION

Patient:_____ Birthdate:_____

Address:_____

Request and Authorize From:

_____
Doctor/Clinic/Facility/Other

_____
Street Address

_____
City State Zip Code

Phone: _____

FAX: _____

Release Information To:

_____
Doctor/Clinic/Facility/Other

_____
Street Address

_____
City State Zip Code

Phone: _____

FAX: _____

Check records to be released

Time Frame: Last: ☐ 3 months ☐ 6 months ☐ 1 year ☐ 2 years ☐ Other: _____

☐ All Medical Records ☐ Operative Reports ☐ Ultrasound
☐ Fluorescein Angiogram/Photos ☐ Other _____

My records are to be released for the following purpose:

☐ Changing Physicians ☐ Continuing Care ☐ Insurance ☐Legal Matters
☐ Personal Copy ☐ Inspection of Records ☐ Other: _____

This authorization will expire in: ***90 days***
I realize that I am entitled to a copy of this authorization form.
REDISCLOSURE: Once this information is released, it may not be protected under federal privacy law (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.

_____ _____ _____
Patient Signature or Legal Representative Relationship Date

Witness:_____

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Corona, CA 92881

29798 Haun Rd., Ste 200
Menifee, CA 92586

41900 Winchester Rd., Ste 201
Temecula, CA 92590

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