CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name_____ Date of Birth: _____

Address: _____

City: _____ State: _____Zip Code: _____

Phone Number: _____Requested Dates: _____

I authorize Retina Institute /Acuity Eye Specialists the disclosure of all protected information for the purpose of review and evaluation related to my medical condition and treatment. I, the patient or patient's representative, have the legal right to inspect, copy and request delivery as specified of this protected health information within the next 30 days in accordance with Section 123110 of the Health & Safety Code. I accept the responsibility of any fees associated with this request.

Release to: _____

Address: _____

Phone: _____ Fax: _____

I have carefully read and understand the foregoing. I consent to the release of the specified medical information by my physicians and their associates or representatives from any liabilities arising from release of the specified information made in good faith in accordance with this consent. I also understand that any information complied in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law.

_____ _____

Signature of Patient, Legal Guardian or Representative **Date**

_____ _____

Printed name of patient, parent, legal Guardian or Representative **Relationship**

Note: Copies of legal documentation supporting legal representation of the patient must accompany this release form. This form must be completed in its entirety to be considered valid. Please anticipate 10 days for processing of this request. **Please email form to medicalrecords@acuityeyegroup.com or fax to (626) 796-7657.**