THE RETINA INSTITUTE
OF MICHIGAN

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT INFORMATION **TODAY'S DATE:** _____

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Preferred Phone: _____ Alternate Phone: _____

Social Security Number: _____ E-Mail Address: _____

I HEREBY AUTHORIZE RECORDS FROM:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

TO BE RELEASED TO:

Retina Institute of Michigan, Dr. Anu Patel
31500 Telegraph Road Suite 005
Bingham Farms, MI 48025
Phone: 248-621-0200 Fax: 248-621-0201

FOR THE PURPOSE OF:

____ Transfer of Care _____Personal Copy ____Disability ____Other: *(please specify)*_____

DATE RANGE: _____ to _____

ITEMS REQUESTED:

_____ Physician Office Notes _____ Imaging records _____ Operative Procedures

_____ Other _____

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing.

Name: _____ Signature: _____ Date:_____