RETINA CONSULTANTS

PRINT FORM

RESET FORM

MedPark Medical Center
4450 31st Avenue S, Ste 200
Fargo, North Dakota 58104
701-293-9829
877-503-0251 Toll Free
701-293-0111 Fax
fargoretina.com

Authorization to Release Protected Health Information

Name *(First, Middle Initial, Last)*	Birth Date *(MM/DD/YYYY)*

Instructions: If **any** section is incomplete, this form may be invalid.

Release Information From:

☐ Retina Consultants, Ltd
4450 31st Avenue S, Ste 200, Fargo, ND 58104

☐ Other *(Specify facility/individual & address below, including phone/fax if known.)*

_____
_____
_____
_____

Release Information To:

☐ Retina Consultants, Ltd
4450 31st Avenue S, Ste 200, Fargo, ND 58104

☐ Other *(Specify facility/individual & address below, including phone/fax if known.)*

_____
_____
_____
_____

Purpose of Release

☐ Treatment/Continued Care
☐ Personal
☐ Other
☐ Disability Determination
☐ Legal Purposes
☐ Application for Insurance
☐ Payment of Insurance Claim

Information to be Released

(Required – check all the apply)

☐ Clinic Notes
☐ OCTs
☐ Fluorescein Angiograms
☐ Retinal or Other Photographs
☐ Visual Field Tests
☐ History and Physical
☐ Hospital Notes
☐ Laboratory Reports
☐ Operative Reports
☐ Pathology Reports
☐ Radiology Reports
☐ Other

Service Dates *(optional):*

From_____ To _____

Information Needed By *(optional):*

_____

Comments *(optional):*

_____
_____
_____
_____

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here: _____

☐ By checking this box, I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

☐ By checking this box, I also authorize the release of records for future visits or stays after the date of my signature until this authorization expires or is revoked.

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms of this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship: ☐ Legal Guardian or Conservator ☐ Health Care Agent (POA)
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature *(Required)* ▶	**Date Signed** *(Required (MM/DD/ YYYY))*
Printed Name of Person Signing *(If not the patient)*	Phone
Mailing Address of the Patient – Street, City, State and Zip	