Retina of Auburn & Metro-Columbus

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AUTHORIZATION TO RECEIVE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to give the authorization as follows.

Name: _____ Date of Birth _____

I hereby authorize

Name of Facility: _____

Address: _____

_____

Phone: _____

to

release to / receive from (select one)

Retina of Auburn & Metro-Columbus any and all pertinent information regarding my medical care.

Specific Information Requested is

- All
- Last Visit Note
- Last Treatment
- A print out of the last OCT
- Other _____

Patient Signature: _____ Date: _____

WITNESSED BY: _____