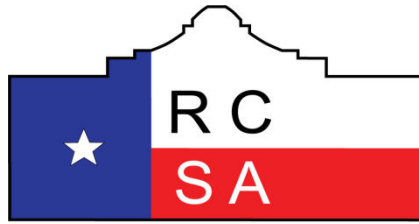


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Retinal Consultants of San Antonio

Expert Care of the Retina, Macula and Vitreous

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____ Date of Birth: ____/____/____

May we leave messages/detailed medical information on voicemail at either of these phone numbers? Yes No

If yes: Home Phone: _____ Cell Phone: _____

May we contact you at your place of employment? Yes No

If so, may we leave a message? Yes No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)? Yes No

If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? Yes No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? Yes No

I hereby authorize Retinal Consultants of San Antonio to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above. I have reviewed Retinal Consultants of San Antonio's Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

X _____
Signature of Patient or Legal Representative

Date

X _____
If Signed by Legal Representative, relationship to Patient

X _____
Signature of Witness