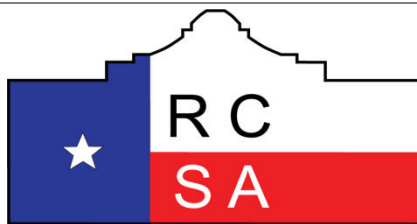


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Expert Care of the Retina, Macula and Vitreous

AUTHORIZATION TO RECEIVE / RELEASE HEALTH RECORDS

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

Home Phone: _____ Cell Phone: _____

I Hereby Authorize the Disclosure of my Health Information From:

Name of Person/Organization Releasing Information: _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Office Fax _____

To Release my Information To:

Name of Person/Organization Releasing Information: _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Office Fax _____

INFORMATION TO BE RELEASED:

_____ Complete Medical Record _____ Other: _____

_____ Medical Records for Specific Dates of Service from _____ to _____

This authorization remains in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X _____
Signature of Patient or Legal Representative

Date

X _____
If Signed by Legal Representative, relationship to Patient
(Attach necessary documents if power of attorney)

X _____
Signature of Witness

Office Use Only: Date Sent: _____ By: _____ Via: _____