Medical Records Release Authorization

Patient Name:_____ **Date of Birth:** _____/_____/_____

MR# (Office use only) _____

Information to be released from: (COMPLETE NAME AND ADDRESS)

_____

_____

_____

_____

Information to be released to:
Mid Michigan Retina, PLC
4660 S. Hagadorn Rd. Suite 200
East Lansing, MI 48823
Phone: (517) 574-5850
Fax: (517) 547-5850

Specific information to be disclosed (include dates of treatment):

_____

Purpose and need for such disclosure:

Number of Pages Released: _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. This authorization will automatically expire six months from date of signature.

I understand that information used or disclosed with my permission may be re disclosed by the recipient and no longer protected by the federal Privacy Standards.

I have read the above and acknowledge that I fully understand the terms and conditions of this authorization.

Patient Signature: _____ **Date:** _____/_____/_____

Legal Gaurdian:_____ **Date:** _____/_____/_____

Witness Date: _____ **Date:** _____/_____/_____