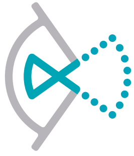

INFINITY · RETINA

Medical Retina and Uveitis Center

AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT NAME: ______________________________ DATE OF BIRTH: ____/____/____

ADDRESS: ______________________________ ZIP CODE: ________________

I HEREBY AUTHORIZE THE DISCLOSURE OF MY HEALTH RECORDS TO:

Infinity Retina
100 Granite Drive
Suite 7
Media, PA 19063

Phone: 610-606-1671
Fax: 215-893-4888

TO RELEASE MY RECORDS FROM:

NAME: ______________________________

PHONE/FAX: ______________________________

E-MAIL: ______________________________

INFORMATION TO BE RELEASED:

- ☐ Complete Medical Record
- ☐ Medical Records specific dates of service from __/__/__ until__/__/__
- ☐ Other (please explain): ______________________________

____

____
PRINTED Name of Patient
OR Personal Representative

____
SIGNATURE of Patient OR
Personal representative

100 Granite Drive | Suite 7 | Media, PA 19063

Welcome@infinityretina.com 610.606.1671 215.893.4888