Janigian Retina Associates
Diseases and Surgery of the Retina and Vitreous
Ocular Inflammatory Diseases

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# AUTHORIZATION TO RECEIVE / RELEASE HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

**I Hereby Authorize the Disclosure of my Health Information From:**

_____
Name of Person/Organization Releasing Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

**To Release my Information To:**

_____
Name of Person/Organization Receiving Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

**INFORMATION TO BE RELEASED:**

_____Complete Medical Record
_____Medical Records for Specific Dates of Service (please list) from_____ to _____
_____Other (please list) _____

**This authorization remains in effect unless otherwise instructed.**.

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X_____ X_____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

_____
Description of Personal Representative's Authority (attach necessary documentation)

**********

**Date Sent:** _____ **By:** _____ **Via:** _____

**120 Dudley Street, Suite 303**
**Providence, Rhode Island 02905**
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