Retina / Vitreous Consultation
Charles A. Garcia, M.D
Hasan Mohidat, M.D.
Rania Tabet, M.D.

Comprehensive Ophthalmology
Geoffrey Collett, M.D.
Charles A. Garcia, M.D.
Hasan Mohidat, M.D.
Joseph F. Ruda, M.D.
Rania Tabet, M.D.

Optometry & Contact Lenses
Lara Fady, O.D.
T. Geoffrey Iszard, O.D.
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Museum District Eye Center
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MEDICAL HEALTH RECORD RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the person(s) or entity listed below. Limitations on the information you may release subject to this Release Form are as follows:

Patient Name: _____ Patient Date of Birth: _____

Patient SS# (last 2 digits only): _____ Patient Contact Number: _____

Doctor or Facility to release records:_____

Release my protected health information to the following person(s)/entity:

Name:_____ Contact Number: _____

DATES OF SERVICE:_____

Address:_____
City State Zip

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. **I understand** that I have the right to revoke this authorization at any time in writing and present it to the organization releasing the information. **I understand** that the revocation will not apply to my insurance company or other providers who are participating in my healthcare treatments. **Unless an expiration date is specified, this authorization will expire is 6 months from the date of request.**

I understand that authorizing this disclosure of health information is voluntary. **I understand** that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Records Privacy Officer for Charles A. Garcia, M.D., P.A..

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO THE PATIENT: I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information. I will not hold Charles A. Garcia, MD, P.A. or my provider(s) liable for any misinterpretation of the information in my medical record as a result of not consulting with my physician for the correct interpretation. **Initial:** _____ **Date:** _____

_____ _____
Printed name of patient or legal guardian Signature of patient or legal guardian

_____ _____
Relationship to patient (if legal guardian) **Date**