Retina Associates
of Western NY, P.C.
Preserving and restoring sight with compassion and innovation

Patient Authorization for Release of Medical Records

PROCESSING FEE: $10.00 per OCT photo; $15.00 per fluorescein angiogram.

Patient's Name:
Address:

DOB:

Please check all information that applies:
☐ Chart Notes
☐ MRI report
☐ X-rays
☐ CAT Scan
☐ Other (please specify):

Please include dates_____

☐ I give my authorization to release the above protected information to RETINA ASSOCIATES OF WNY, PC
☐ I am authorizing RETINA ASSOCIATES OF WNY, PC to disclose or release the above protected information to the following person or organization. The following will receive and use my protected health information:
Name:
Address:
Fax #:

Select one of the following choices:
☐ This authorization will end on the following date: 00/00/0000
☐ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use/or disclosure. Describe the event below:

Signature of Patient:
Name of Patient:
Date:

Practice Limited to Diseases and Surgery of the Retina and Vitreous

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