RECORD RELEASE FORM

800.255.7188. WWW.CENTRALFLORIDARETINA.COM

Name ______________________________ Date ____________

DOB ____________

Records Requested

Provide dates, diagnosis, treatment or any other indications of the specific information you desire:

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Authorization to Release Information

I authorize: ______________________________________

(Physician or Institution)

____

(Address)

____

(City, State & Zip Code)

to release the above requested records to:

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This authorization will remain in effect for six months, at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by the patient at anytime.

This information is **CONFIDENTIAL**. Redisclosure of this information is strictly prohibited by law without the written permission of the person to whom it pertains.

The undersigned hereby releases the above mentioned physician or institution from any liability which may arise from release and/or examination of the information indicated above. I understand that there may be a charge for copies and record review and that such charges must be paid prior to review or release of copies.

SPECIAL CONSENT: I also authorize the release of information regarding HIV, AIDS, or AIDS related status to the person/institution named above.

Signature ____