RETINA CENTER
O F V E R M O N T

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: Retina Center of Vermont

Address: 181 Saint Paul Street

City: Burlington State: VT Zip Code: 05401

This request and authorization applies to:

☒ Healthcare information relating to the following treatment, condition, or dates: ______________
All eye related visits (including laser and/or other procedure appointments, angiography data forms) and physician incoming and outgoing correspondence

☒ Ultrasound prints (original quality or photographic quality duplicates)

☒ Photos: Photographic quality prints or digital files (in .jpg or .tif format) of digital photographic and angiographic studies as well as representative 35 mm color slide duplications of non-digital color images

Comments:

Please mail the above information to Retina Center of Vermont upon receipt of this notification.

Patient Signature: ______________________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.