TAYANI INSTITUTE
Ophthalmology - Plastic Surgery - Optometry

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AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

PATIENT NAME: _____

Social Security No. _____ **Birth Date:** _____ **Daytime Telephone:** _____

I HEREBY AUTHORIZE MEDICAL RECORDS INFORMATION ABOUT ME TO BE RELEASED FROM:

Physician/Medical Organization: _____

Complete Address: _____

Telephone: _____ Fax: _____

RELEASED MEDICAL RECORDS INFORMATION ABOUT ME SHOULD BE DELIVERED TO:

Physician/Medical Organization: _____

Complete Address: _____

Telephone: _____ Fax: _____

TYPE OR EXTENT OF INFORMATION TO BE RELEASED:

_ Medical History, Examination, Reports/Notes	_ Laboratory Reports	_ Prescriptions
_ Surgery Reports/Notes	_ Treatment and/or Test Results	_ Diagnostic Test Results
_ Hospital Records Including Reports	_ Consultation Reports	_ HIV Test Results
_ Duplicates of Clinical Photographs	_ Visual Field Print-Outs/Plots	_ Alcohol and/or Drug Abuse Reports

PURPOSE/NEED FOR RELEASE: _____

THIS AUTHORIZATION WILL BE EFFECTIVE FOR MEDICAL RECORDS GATHERED TO THE DATE OF SIGNATURE AND WILL REMAIN IN EFFECT UNTIL 1 YEAR

_ _____

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

By my signature I authorize release of my medical records. I understand that I may revoke this authorization at any time by providing my written revocation.

_____ _____ _____

***Signature of Patient/Representative** **PRINT NAME** **Date**

IF THIS DOCUMENT IS SIGNED BY ANY PERSON OTHER THAN THE PATIENT, STATE RELATIONSHIP TO PATIENT

Patient is: _ Minor _ Other

Representative is: _ Parent or Legal Guardian _ Caregiver _ Other

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION