Authorization for the Release of Medical Information

_____ (patient) authorizes

(name and address of physician): _____

_____

to furnish records and medical information to West Coast Retina Medical Group.

All information about the care and treatment of the above-named patient may be released, including but not limited to information about general medical care, out-patient treatment with a psychotherapist, and substance abuse/chemical dependency treatment, with the following exceptions: _____

PLEASE NOTE: For the release of ***specially-protected medical information*** [e.g., federal- or state-assisted drug and/or alcohol abuse treatment records, and HIV test results], the box below must be completed by the patient or his/her representative.

Disclosure of the records/information may be used **only** for the following purposes: _____

_____

I have been advised of my right to receive a copy of this form.

Print Name: _____ Date: _____

Signature: _____ This authorization expires on: _____

* **If form is not signed by patient, indicate relationship of signer:**

- ☐ Parent or guardian of minor patient (for care for which the minor was not permitted to consent)
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient
- ☐ Spouse or person financially responsible (solely when information is needed to process application for dependent health care coverage)

Special Authorization for the Release of Specially-Protected Medical Information

I authorize release to the above-listed recipient the following records concerning the patient designated above.

_____ Drug and/or alcohol abuse records of federal-or state-assisted programs.
Initials

_____ HIV test results. Print Name: _____
Initials

Signed: _____ Date: _____

Patient or Authorized Representative

1445 Bush Street, San Francisco, California 94109
(415) 972-4600 • Fax (415) 975-0999