VITREO RETINAL SURGEONS

THOMAS G. WARD, D.O.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ ACCT #: _____

DOB: _____ SS#: _____

I hereby authorize Dr. _____ to release the information from my medical records to: _____ at _____

for the following reason: _____
for the following date range: _____ to _____

Included should be the following records:

_____H & P
_____Office Visit Notes
_____Op/Procedure Reports
_____Patient Information Sheets
_____Imaging/Radiology Reports
_____Bloodwork/Lab Reports
_____EKG
_____Other: _____

I have read the above release, and authorize the above facility to release the information specified. I understand that I have the right to withdraw this request in writing to the appropriate party, except in the case where the authorized release has already been carried out.

This authorization will expire 90 days from the date signed below and covers only the dates specified above.

Patient Signature: _____ Date: _____

Relationship to Patient: _____
(If other than self, i.e. Parent, Guardian, Power of Attorney)

*If signer has Power of Attorney, a copy of the documents must be furnished to our office.

(PLEASE PRINT AND MAIL OR BRING INTO THE OFFICE FOR RELEASE OF RECORDS)