Retina Associates of South Texas

Diseases and Surgery of the Retina and Vitreous

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Medical Information Release Form

HIPAA Release Form

Name: ____ **Date of Birth:** _____/____/_____

Telephone #: ___________________________________

Release of Information

[ ] I authorize Retina Associates of South Texas, P.A., the release of information including the diagnosis, medical records; examination rendered to me and claims information.

This information may be released to:

[ ] Spouse____

[ ] Child(ren)____

[ ] Physician____

[ ] Other____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signed: ______________________________________ Date: ____/____/_____

Fee Schedule:

Medical Records $25 (50 pages or less) $50 (51 pages or more) • Form requiring physician signature $25 per form • Diagnostic Imaging $8 per copy