RECORDS RELEASE AUTHORIZATION

TO: _____
_____
_____

I hereby authorize and request you to release my records to:

MANDELL RETINA CENTER
397 Little Neck Road
3300 S. Bldg., Ste. 202
Virginia Beach, VA 23452
Phone: 757-227-4300
Fax: 757-486-3125

My medical records, including the diagnosis and any treatment or examination rendered to me.

Patient Name: **(please print)** _____

Patient Signature: _____
(or authorized signature)

Date of Birth: _____

Witness: _____**Date:** _____

CONFIDENTIAL: The PHI (personal health information) contained in the form is Highly Confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such.