CENTER FOR VITREO RETINAL DISEASES

DR. IRA GAROON & DR. ROBERT GAROON

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name :_____

Patient date of birth :_____

I hereby authorize Dr. Garoon to release copies of my protected health information to:

_____

_____

_____

This information should include:

☐ Copies of my entire medical record, which may include demographic or billing information:

☐ The following information only:

_____

_____

_____

This information is being requested for the following purpose(s):

_____

_____

_____ _____

Signature of patient or authorized representative Date

_____

Relationship of representative if not signed by patient

This authorization shall remain in effect for ninety days until revoked in writing earlier.