PAMELA GOLCHET, MD
DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY
DISEASES OF THE RETINA & VITREOUS

Authorization to Release Information to Designated Individuals

Many of our patients allow family members such as their spouse, significant other, parents, children, or a friend to call and request information regarding their medical status and/or financial information. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any person, please sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent shall remain in effect until revoked by you in writing. This request and authorization apply to:

☐ Healthcare information relating to the following treatment, condition, or dates:
_____

_____

☐ All healthcare information ☐ Other: _____

I authorize Visionary Retina Center to release my records and any information as requested above to the following individuals.

1. _____ Relation to Patient:_____
2. _____ Relation to Patient:_____
3. _____ Relation to Patient:_____

_____
SIGNATURE – Patient or Patient's Authorized Representative Date

PRINT NAME - Patient or Patient's Authorized Representative Relationship to Patient

WITNESS – Name and Signature Date

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