Retina Specialists
DR. THOMPSON ● DR. SJAARDA ● DR. BARANANO

Authorization to Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize_____to release healthcare information of the patient named above to Retina Specialist at the location checked below:

☐ **Towson Office**	☐ **Frederick Office**	☐ **Columbia Office**
6569 N. Charles Street	77 Thomas Johnson Drive	9700 Broken Land Parkway
Suite 605	Suite B	Suite 105
Towson, MD 21204	Frederick, MD 21702	Columbia, MD 21046
TEL: (410)296-9700	**TEL:** (301)682-9700	**TEL**: (410) 772-9700
FAX: (410)296-9705	**FAX:** (301)682-3578	**FAX:** (410) 772-9755

This request and authorization applies to:

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

☐ All healthcare information

☐ Other:_____

- The purpose for disclosing the information: _____
- I understand that the information used or disclosed may be subject to re-disclosure by Retina Specialist, and would then no longer be protected by federal privacy regulations.
- I may revoke this authorization by notifying Retina Specialists in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Patient Signature _____Date Signed_____

Patient's Representative _____Date Signed_____
Signature and Description of Authority

This Authorization Expires one year after it is signed.