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RETINA, MACULA AND VITREOUS
DISEASES AND SURGERY
FLUORESCEIN ANGIOGRAPHY

Authorization to Receive / Release Health Information

Patient Information

Patient Name _____ Date of Birth_____ Account #_____

Address _____ City _____ State_____ Zip _____

Name and Address of Covered Person/Institution to *Receive* Information

_____

_____

_____

Name and Address of Covered Person/Institution to *Release* Information

_____

_____

_____

The Information Below Will Be Used for Patient Care

Medical Records for Specific Dates of Service (please list) from _____ to _____

I hereby authorize the release of protected health information regarding the above-named person be forwarded. This authorization shall remain valid unless revoked but will expire in 1 year after signing.

_____ _____ _____

Printed Name of Patient or Personal Represent | Signature of Patient or Personal Representative | Date

_____

Witness

1100 W. CENTRAL RD., SUITE LL-2, ARLINGTON HEIGHTS, ILLINOIS 60005 (847) 394-3933 FAX (847) 394-4099
8901 W. GOLF RD., SUITE 206, GOLF SURGICAL BUILDING & MEDICAL OFFICES, DES PLAINES, ILLINOIS 60016 (847) 699-0006 FAX (847) 699-1744
1555 BARRINGTON RD., SUITE 4500, BUILDING 3, ST. ALEXIUS HOSPITAL, HOFFMAN ESTATES, ILLINOIS 60169 (847) 882-1840 FAX (847) 394-4099
800 BIESTERFIELD RD., SUITE 730, EBERLE BUILDING, ALEXIAN BROTHERS HOSPITAL, ELK GROVE VILLAGE, ILLINOIS 60007 (847) 394-3933 FAX (847) 394-4099
7447 W. TALCOTT, SUITE 367, RESURRECTION MEDICAL CENTER, CHICAGO, ILLINOIS 60631 (847) 699-0006 FAX (847) 699-1744