Authorization for Release of Confidential Health Information

REQUESTING RECORDS TO BE SENT FROM:

Doctor's Name _____

Address _____

Phone _____ **Fax** _____

TO: Apex Retina Institute

Darren Knight, M.D.

2880 Atlantic Avenue, Ste 290

Long Beach, CA 90806

Phone: (562)-534-1777 Fax: (562) 534-1772

Please release records from _____ to _____ for the following:

☐The entire medical record, excluding mental health, alcoholism, drug abuse, and HIV/acquired immune deficiency syndrome (AIDS) treatment records

☐Mental health treatment records

☐Alcoholism Treatment Records

☐Drug Abuse Treatment Records

☐Laboratory Reports

☐Imaging Reports

☐Operative Notes

☐Other _____

We are especially interested in _____

_____

PATIENT NAME (print) _____ Birthdate _____

SIGNATURE _____ Date _____