



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **Joshi Retina Institute** to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

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

- All healthcare information

- Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

In accordance with HIPPA PHI regulations: This message may contain legally, privileged or confidential information. If you are not the intended recipient of this message, please notify us, disregard the forgoing message, and return to us. We apologize for any inconvenience this may have caused.