RETINA INSTITUTE OF NORTH CAROLINA, PC

RELEASE OF MEDICAL INFORMATION

PLEASE PRINT YOUR LEGAL NAME: ____

BY SIGNING BELOW, I AUTHORIZE RETINA INSTITUTE OF NORTH CAROLINA, PC, TO RELEASE MY MEDICAL AND BILLING INFORMATION TO:

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	□ YES	□ NO	______________________________
CHILDREN	□ YES	□ NO	______________________________
IN-LAWS	□ YES	□ NO	______________________________
CAREGIVERS	□ YES	□ NO	______________________________
PARENTS	□ YES	□ NO	______________________________

OTHERS ______________________________ **RELATIONSHIP TO PATIENT ________________________**

We ask if you have any change in this request that you please inform the receptionist.

RETINA INSTITUTE OF NORTH CAROLINA, PC, MAY LEAVE APPOINTMENT INFORMATION ON MY VOICEMAIL:

HOME	□ YES	□ NO
CELL	□ YES	□ NO
WORK	□ YES	□ NO
RELATIVE	□ YES	□ NO

I AUTHORIZE THE FOLLOWING TO PICK UP PRESCRIPTIONS, X-RAYS, MEDICAL RECORDS, ETC…

RELATIONSHIP			**NAME OF DESIGNATED PERSON**
SPOUSE	□ YES	□ NO	______________________________
RELATIVE	□ YES	□ NO	______________________________
CAREGIVER	□ YES	□ NO	______________________________

OTHERS ______________________________ **RELATIONSHIP TO PATIENT ________________________**

PATIENT SIGNATURE ______________________________________ DATE ______________________

I UNDERSTAND THAT THE RETINA INSTITUTE OF NORTH CAROLINA, PC, WILL ASK FOR IDENTIFICATION OF THE PERSON PICKING UP PATIENT MEDICAL INFORMATION OR PRODUCTS.