**MIDWEST RETINA CONSULTANTS, S.C.**

**GEORGE J. WYHINNY, M.D.**
**DANIEL C. ALTER, M.D., Ph.D.**
**ENRIQUE GARCIA-VALENZUELA, M.D., Ph.D.**
**BRYAN M. KIM, M.D.**
**HARI N. MYLVAGANAM, M.D.**

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) 698-6300 FAX (847) 698-6002
1555 BARRINGTON RD., SUITE 4500, BUILDING 3, ST. ALEXIUS HOSPITAL, HOFFMAN ESTATES, ILLINOIS 60169 (847) 882-1840 FAX (847) 394-4099
800 BIESTERFIELD, SUITE 730, EBERLE BUILDING, ALEXIAN BROTHERS HOSPITAL, ELK GROVE VILLAGE, ILLINOIS 60007 (847) 394-3933 FAX (847) 394-4099
5015 N. PAULINA ST., SUITE 204, PAVILION BUILDING, BETHANY METHODIST HOSPITAL, CHICAGO, ILLINOIS 60640 (847) 698-6300 FAX (847) 698-6002