Midwest Retina Consultants, S.C.
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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., Suite LL-2, Arlington Heights, IL 60005 Phone: 847-394-3933 Fax: 847-394-4099
8901 W. Golf Suite 206, Golf Surgical Building, Des Plaines, IL, 60016 Phone: 847-699-0006 Fax: 847-699-1744
1555 Barrington Rd Suite #4500 Building #3 St Alexius Hospital Hoffman Estates, IL 60169 Phone: 847-882-1840 Fax: 847-394-4099
800 Biesterfield, Suite #700, Eberle Building, Alexian Brothers Hospital, Elk Grove Village, IL 60007 Phone: 847-394-3933 Fax: 847-394-4099
7447 W. Talcott, #367, Resurrection Medical Center, Chicago, IL, 60631 Phone: 847-699-0006 Fax: 847-699-1744