MEDICAL RECORDS AUTHORIZATION FORM
Midwest Retina Consultants

Main Office: 1100 W Central Rd, LL2, Arlington Heights, IL 60005

Phone: 847-394-3933 Fax: 847-394-4099

Patient Name: _____

Date of Birth: _____ Phone Number: _____

AUTHORIZATION

I hereby authorize Midwest Retina Consultants and its providers:
- Dr. Daniel Alter
- Dr. Enrique Garcia-Valenzuela
- Dr. Bryan Kim
- Dr. Anand Gopal
- Dr. Rehan Hussain

To:
☐ Release my medical records to
☐ Obtain my medical records from

RECIPIENT / SENDER INFORMATION

Name of Facility / Provider: _____

Address: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED

☐ Complete Medical Record
☐ Office Visit Notes
☐ Imaging (OCT, Fundus Photos, Angiography)
☐ Operative Reports
☐ Injection Records
☐ Billing Records
☐ Other: _____

This authorization applies to all Midwest Retina Consultants locations, including Arlington Heights, Des Plaines, Elk Grove, Hoffman Estates, and Chicago. All medical records requests are processed centrally.

DATE RANGE

From: _____ To: _____

PURPOSE OF DISCLOSURE

☐ Continuity of Care
☐ Second Opinion
☐ Personal Use
☐ Legal
☐ Insurance
☐ Other: _____

ACKNOWLEDGMENTS

I understand that this authorization is voluntary. I may revoke this authorization at any time in writing, except to the extent that action has already been taken. Information disclosed may be subject to re-disclosure and may no longer be protected by federal privacy regulations. This authorization will expire one (1) year from the date of signature unless otherwise specified.

SIGNATURE

Patient / Legal Representative Name: _____

Signature: _____

Date: _____

Relationship to Patient (if not self): _____

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