Retina Group of Florida™
Expert Care. Compassionate Touch.

Request for Records Release

Date:_____

_____
(Doctor)

_____
(Phone)

_____
(Fax)

Send To: **Retina Group of Florida**

_____
(Doctor)

_____
(Phone)

_____
(Fax)

I hereby authorize you to release records to Retina Group of Florida, my Personal Health Information and my Medical Record including diagnosis, testing, & treatment during the period from

_____ to _____.

Print Patient Name:_____ Phone:_____

Patient address:_____

Date of Birth:_____ SS#:_____

Patient Signature:_____

Date:_____ Witness:_____

Please pay special attention to:
Initial Evaluation
Follow Up Notes
Fluorescein Angiogram(s)
Retinal Drawings

We want you to know that RGF, its' Employees, Managers, and Physicians continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule."