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MEDICAL RELEASE AUTHORIZATION

Patient name: (please print) _____
Date of birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (home) _____ (work) _____

I, the undersigned, authorize and request San Diego Vitreoretinal Associates to: Release Obtain information (to/from) the following physician/organization/person:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (work) _____ (fax) _____

Please release medical / billing records regarding the care/treatment that I have received from dates of service beginning _____ through _____.

Purpose for release of information: _____

This authorization is effective for no longer than one year from the day it was signed and I understand this authorization can be revoked at any time. I hereby release any person, agency, facility, or organization from any liability or legal responsibility for information pursuant to this authorization.

I understand that San Diego Vitreoretinal Associates may charge a fee for copying my records or providing a summary of my medical records.

Signed: X _____ Date: _____

Name: (print) _____