Retina Consultants of Southern Colorado, P.C.
Medical Record Release

Date: _____

I _____ /_____ give permission for my Medical Records to be
PATIENT NAME D.O.B.

released to: _____

Access method:

You have the right to obtain a copy of your Medical Records or have it sent to another Doctors Office. Please indicate your method of delivery.

( ) I will return to Retina Consultants of Southern Colorado, P.C. and pick up the copy when it is ready.

( ) I would like Retina Consultants of Southern Colorado, P.C. to send the copy via U.S. mail to the following address: _____
_____

( ) I would like Retina Consultants of Southern Colorado, P.C. to send a copy via fax to the following number: _____
_____

( ) If you would like a copy of your Fundus Photos or Fluorescein Angiogram, there is an $18.00 processing fee.

I understand that Retina Consultants of Southern Colorado, P.C. is given fifteen days to process my request if my information is maintained on site. Thirty days if information is maintained offsite.

Signature: _____

Witness: _____

Date: _____