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Disease and surgery of retina and vitreous, glaucoma, diabetic retinopathy, ocular trauma

REQUEST FOR RELEASE OF MEDICAL RECORDS

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_____

I understand that I have the right to revoke this authorization, in writing at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to consent a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Shashi Dharma, M.D., 6500 Sierra Drive #170, Irving, TX 75039.

I understand that it is possible that information used or disclosed with my permission may be redisclosed by the recipient and no longer protected by the federal privacy standards.

I HEREBY REQUEST THAT MY MEDICAL RECORDS TO BE RELEASED TO;

Name: _____

Address:_____

_____

OUR CHARGE FOR MEDICAL RECORDS IS $30.00. RECORDS WILL BE SENT WHEN PAYMENT IS RECEIVED.

Description of each purpose of the requested use or disclosure:

_____

_____

Description of the information to be released:

_____

_____

Witness:_____

Date:_____

Patient:_____

Print Name:_____

Date:_____

DOB:_____