Coastal Retina Institute

836 East 65th Street, Bldg#38
Savannah, GA 31410
t (912) 376-2030
f (912) 600-1959

Medical Records Release Authorization

Patient Information

Date: _____

Patient Name: _____ Patient DOB: _____

Patient Phone: _____ Physician E-mail: _____

Patient Address: _____

I hereby authorize records from:

Physician/Hospital Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Date Range: _____

To be released to:
Coastal Retina Institute
836 East 65th Street, Bldg #38
Savannah, GA – 31405
Ph: (912) 376-2030
Fax: (912) 600-1959

Purpose:

- ○ Transfer of Care
- ○ Personal Copy
- ○ Disability
- ○ Other _____

Items Requested:

- ○ Office Notes
- ○ Imaging Records
- ○ Operative Procedures
- ○ Other _____

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that I have a right to revoke this authorization at any time. I understand that if I revoking this authorization, I must do it in writing.

Name: _____ Signature: _____ Date: _____