Authorization for Release of Medical Records

I, _____ hereby request that
(Please Print)
_____ provide in writing to

DELAWARE EYE INSTITUTE
18791 John J. Williams Highway
Rehoboth Beach, DE 19971
(302) 645-2355 - Fax

a copy of all my medical records. I understand that this medical information may include results of HIV testing and AIDS diagnosis.

This release is effective from _____ to _____.

Thank you for your help.

_____ Signed: _____
(Witness)

_____ Date of Birth: _____
(Date)

OFFICE USE ONLY
Date Completed: _____ Mailed _____ Faxed _____ To Pt _____

Form: 0306-B