REQUEST TO RELEASE MEDICAL RECORDS

Use and Disclosure of Protected Health Information

Center For Retinal Diseases and Surgery, LLC (CRDS,LLC)

Patient's Name ____

Medical Record or Social Security # ____________________________________

1. Persons or group of persons authorized to **use/disclose** this information

   Center For Retinal Diseases and Surgery, LLC (CRDS,LLC)
   6420 Rockledge Drive Suite 4900
   Bethesda, MD 20817

2. Persons or group of persons authorized to **receive** this information

3. Description of the information to be used or disclosed:

4. *Purpose for disclosure of information:*

5. I understand that if the party receiving this information is not a health care provider or health plan subject to the federal privacy regulations that the information described above may be re-disclosed and no longer protected by the privacy regulations. _______________ (Patient Initials)
6. I understand that I may revoke this authorization in writing at any time. Please refer to CRDS, LLC's "Notice of Privacy Practices". I understand that CRDS, LLC will be unable to take back any disclosures that were made prior to my written revocation of this authorization. ____________ (Patient Initials)
7. I understand that I may refuse to sign this authorization and that if I do, it will not affect my ability to obtain treatment or payment or eligibility for benefits.* _____________ (Patient Initials) *This section would only apply if the request for the disclosure of the information was not initiated by the patient.
8. I understand that I may inspect or copy any information used or disclosed under this authorization. ______________ (Patient Initials)
9. This authorization becomes effective __________________ and will expire on _____________.

____________________________________ ____________________

Patient (or Representative*) Signature Date

____ __________________

Name of Personal Representative (Please print) Relationship to Patient