MICHAEL J. DRINNAN, M.D.
DONNA B. ORNITZ, M.D
THOMAS D. NEUMAYR, M.D.
BEVERLY L. SARVER, M.D.
JACQUELINE T. KOO, M.D.

AUTHORIZATION TO RELEASE/OBTAIN PATIENT MEDICAL INFORMATION

I hereby authorize Peninsula Eye Physicians to release/obtain my medical information as listed:

Patient Name________________________Date of Birth___________________

Address____________________________City__________State____Zip______

Phone__________________

OBTAIN FROM: **RELEASE TO:**

OBTAIN FROM	RELEASE TO
_________________________________	___________________________
NAME	**NAME**
_________________________________	___________________________
ADDRESS	**ADDRESS**
_________________________________	____________________________
CITY,STATE,ZIP	**CITY,STATE,ZIP**

INFORMATION REQUESTED
_____Entire medical record
_____Lab results
_____x-ray results
_____Last exam
____ Other________________________

SPECIFIED DATES
From:__________

To:____________

Information Protected by State/Federal Law
___Drug abuse diagnosis/treatment From:_____To:______
___Alcoholism diagnosis/treatment From:_____To:______
___Mental Health diagnosis/treatment From:_____To:______
___Sexually transmitted disease diagnosis From:_____To:______
___Treatment or counseling(AIDS/HIV)
NOTE: THERE IS A $10.00 FEE FOR COPYING MEDICAL RECORDS.

I UNDERSTAND THAT THIS AUTHORIZATION IS VALID FOR 90 DAYS AND MAY BE REVOKED IN WRITING AT ANY TIME PRIOR TO 14 DAYS BY NOTIFYING MEDICAL RECORDS.

____ _________________________
Signature of Patient or legally responsible party ***Date of Request***

_______________________***Date received***________***Initials***