Macular Research Institute
Retina Vitreous CENTER PC
William S. Rodden, M.D.
Christine R. Gonzales, M.D.
John D. Hyatt, M.D.

246 Catalina Drive, Suite 1, Ashland, OR 97520
Phone (541) 488-3192
Fax (541) 488-0646

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Patient Name _____ Date _____

Date of Birth _____ Telephone _____

Social Security No. _____

I authorize _____ to release a copy of my medical information to:

Retina & Vitreous Center of Southern Oregon
Dr. William S. Rodden, Dr. Christine R. Gonzales and Dr. John D. Hyatt
Fax (541) 488-0646

We are requesting health information in the following records:

- ☐ Full Medical Records Including any Infections such as Hepatitis and HIV
- ☐ Limited Medical Records (Date range): _____
- ☐ Billing Records (Date range): _____
- ☐ Diagnostic Tests: _____
- ☐ Other _____

Reason for Request: _____

_____ _____

Signature of Patient or Guardian* **Print Name of Patient or Guardian**

* If this request is being signed by an individual's personal representative, please state the basis for the representative's authority: _____ (e.g., state law, court order, etc.).