Retina Macula Specialists, PLLC
660 Shoreview Avenue, Winter Park, FL 32789
100 Park Pl Blvd, Ste 202, Kissimmee, FL 34741
407-931-1510

Authorization to Use or Disclose Protected Health Information

Release of medical records · HIPAA authorization (45 CFR 164.508) · Form revised November 11, 2026

Use this form to have your records sent from Retina Macula Specialists to someone else, or to have another provider send records to us. Complete every section; incomplete forms cannot be processed.

1. Patient

Patient name (print) _____ Date of birth _____

Address _____ Phone _____

2. Direction of release

☐ I authorize **Retina Macula Specialists, PLLC** to release my records **to** the person or organization below.
☐ I authorize the person or organization below to release my records **to Retina Macula Specialists, PLLC**, 100 Park Pl Blvd, Ste 202, Kissimmee, FL 34741, fax 407-931-3759.

Name / organization _____ Phone _____

Address _____ Fax or secure email _____

3. Information to be released

☐ complete medical record ☐ office visit notes ☐ imaging (OCT, angiography, photographs) ☐ operative reports ☐ billing records

☐ other: _____

Dates of service from _____ to _____

4. Sensitive information (initial each item you want included)

_____ HIV/AIDS test results _____ mental health records _____ substance use disorder treatment records (42 CFR Part 2)

Without your initials these are not released, even if “complete medical record” is checked.

5. Purpose

☐ continuing care ☐ personal use ☐ insurance ☐ legal ☐ other: _____

6. Expiration

This authorization expires on _____ or one year from the date signed, whichever comes first.

7. Your rights

- **Right to revoke.** You may revoke this authorization at any time by writing to the Privacy Officer, Retina Macula Specialists, PLLC, 100 Park Pl Blvd, Ste 202, Kissimmee, FL 34741, except to the extent we have already acted on it.
- **No conditioning.** We will not condition your treatment, payment, enrollment, or eligibility for benefits on whether you sign this form.
- **Redisclosure.** Information released under this authorization may be redisclosed by the recipient and may no longer be protected by federal privacy law.
- **Fees.** A copying fee permitted by Florida law (Rule 64B8-10.003, Florida Administrative Code) may apply to copies for personal or legal use; ask our staff.
- **Copy.** You have the right to receive a copy of this signed form.

8. Delivery

☐ mail ☐ fax ☐ secure email ☐ pick up in person (photo ID required)

Signature of patient or legal representative _____ Date _____

If signed by a representative: printed name _____ Relationship / authority (attach documentation) _____

For office use: identity verified ☐ · received by _____ on _____ · sent on _____ by _____.