



MEDICAL RECORDS RELEASE

Patient Name: _____ DOB: _____

Release to Our Office

I hereby authorize _____ to release my records

The complete medical records in your possession, concerning my illness and/or management during the period

From _____ to _____ or all records
Date first Seen Date last seen

To: Macula Retina Vitreous Center Mehran
Taban MD
Phone: (424) 247-9090
Fax: (424)247-9095
Email: drtaban@mrvcenr.com

Release to Another Office

I hereby authorize Mehran Taban, M.D. to release my Medical records to:

Patient Doctor Hospital Other

Name of Patient, Doctor, Hospital, or Other

Phone #: _____ Fax # _____

From _____ to _____ or all records
Date first Seen Date last seen

Medical records to be: Faxed Mailed Picked up

Confidentiality Policy

Medical records are maintained to serve the patient and the health care providers in accordance with legal and regulatory requirements. The information contained in medical records is considered highly confidential.

All patient care information shall be regarded as confidential and available only to authorized users.

The term "Medical records" includes any test results, any medical reports, patient chart notes, claims, billing records and any correspondence relating to the care of a patient

Patient Signature

Date