**Retina Institute of Washington**
George Ko, MD FACS
Kenneth Fung, MD
Syed Mahmood Ali Shah, MD
Michael Waxman, MD

**I authorize ________________________________________, to disclose the following health care information to: ______________________________.**

**☑ All health care information in my medical record concerning my medical findings and treatment. Please include all Fluorescein Angiograms and color photos as appropriate.**

**❒ Health care information in my medical record relating to the following treatment or condition: ________________________________________**

**❒ Health care information in my medicare record for the date(s):____________**

**__________________________________________________________**

**❒ Other (e.g., X-Rays, Bills), date(s):________________________________You may use or disclose health care information regarding testing, diagnosis. and treatment for (check all that apply)**

❒ HIV (AIDS) ❒ STDs ❒ Psychiatric Disorders/ Mental Health ❒ Drug/Alcohol Use

**Reason(s) for this authorization (check all that apply):**

☑ At my request ❒ Other (specify):________________________________

**This authorization ends:** ☑ 90 days from signed date ❒ Other:________________

*Patient full name (printed):*________________________________________

*DOB:*____________________ *SS#:* --------------------______ *Today's Date:*____________

***Patient Signature:*** ______________________________________________

*Specializing in Vitreo-Retinal Diseases and Surgery*
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