RETINA CONSULTANTS
25 YEARS

Mailing Address
PO Box 3970
Charleston, WV 25339

Charleston Office
(Administrative Office)
331 Laidley Street
Suite 301
Charleston, WV 25301

Phone 304-346-4400
Fax 304-346-0704

Parkersburg Office
4421 Emerson Avenue
#200
Parkersburg, WV 26101

Phone 304-485-6301
Fax 304-485-6318

Beckley Office
223 George Street
Suite 3
Beckley, WV 25801

Phone 304-252-2558
Fax 304-252-2628

Huntington Office
1151 Hal Greer Blvd.
Huntington, WV 25701

Phone 304-736-9459
Fax 304-736-9461

Logan Office
148 Enterprise Avenue
Logan, WV 25601
Phone 304-752-4694
Fax 304-752-0599

Pt. Pleasant Office
2502 Jefferson Avenue
Pt. Pleasant, WV 25550

Phone 304-346-4400
Fax 304-346-0704

Pikeville, KY Office
5425 North Mayo Trail
Suite 202
Pikeville, KY 41501-2965

Phone 606-200-5353
Fax 606-200-5352

RETINA CONSULTANTS, PLLC

R. MARK HATFIELD, MD, FACS · ROBERT F. DUNDERVILL, III, MD, FACS
DAVID J. HUNT, MD · ABRAHAM S. MITIAS, MD, FACS · SCOTT C. JAMERSON, MD, FACS
K. ELLEN FRANK, MD · JOSEPH A. BROWN, DO · CHAITANYA INDUKURI, MD

Practice Limited to
Diseases and Surgery of the Retina, Macula, and Vitreous
Diabetic Retinopathy
Macular Degeneration
Ultrasonography

Authorization to Request Health Information

Patient Name: _____ Account #: _____

Date of Birth: _____/_____/_____ Patient Phone Number: _____

Patient Address: _____

I authorize (name and address) _____
to release my health information, as described below.

1. Description of health information that may be released (include dates):

_____

_____

2. The information may be released to Retina Consultants, PLLC, PO Box 3970, Chas., WV 25339 ☐R. Mark Hatfield, MD ☐Robert F. Dundervill, III, MD ☐David J. Hunt, MD ☐Abraham S. Mitias, MD ☐Scott C. Jamerson, MD ☐K. Ellen Frank, MD ☐Joseph A. Brown, DO

3. The purpose(s) for which the information is being requested (if initiated by the individual, it is permissible to state "at the request of the individual"):

_____

_____

4. I understand that I may revoke this authorization in writing at any time by sending a written request to the practice at the above address, except to the extent that action has been taken in reliance on this authorization. I understand that I am not required to sign this authorization as a condition for obtaining treatment, payment, enrollment or eligibility for benefits. I understand that information disclosed pursuant to this authorization potentially could be subject to redisclosure by the recipient, and if redisclosed the information would no longer be protected by the federal privacy rule.

5. Expiration date or event relating to purpose for release: _____

_____

By signing below, I acknowledge that I have read and understand this authorization form.

_____ _____/_____/_____
Signature of Patient or Patient's Authorized Representative Date

If signed by Patient's Representative, please print name and describe the representative's authority to act for the patient:

Representative's Name: _____

Representative's Authority: _____

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FOR OFFICE USE ONLY:
Release ☐Faxed by _____; date _____ ☐Mailed by _____; date _____
Records ☐Faxed by _____; date _____ ☐Mailed by _____; date _____
Other: _____