Molecular Genetics of Inherited Eye Diseases
University of California
Authorization for Release of Medical Records

Patient's Name ____

Address ____

City, State, Zip Code ____

Phone ________________________ Date of Birth ___________

I authorize release of information from:

Name of Eye Doctor ____

Address ____

City, State, Zip Code ____

Phone ________________________Fax__________________________

I authorize the above institution to release all information related to the eyes and eye examination, including photos and fluorescein angiograms. This information will be used for a study on inherited eye diseases. This consent is for this single request only.

*THIS IS A REQUEST FOR MEDICAL *INFORMATION* ONLY—NOT A REQUEST FOR ADDITIONAL EXAMS.

Please send the above information to:

Dr. Thorson, John A., Ph.D.
Attention: Dr. Radha Ayyagari, Ph.D.
Ophthalmic Molecular Diagnostics Laboratory
Shiley Eye Center
Room 326; 9415 Campus Point Drive
La Jolla, California- 92037
Phone: (858) 534-5362 or FAX: 858-246-0568

It is important to understand that once your medical records have been disclosed they may no longer be protected directly by federal privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). However, as long as the information is held in any part of the University of Michigan Health System, it is protected by the Health System's privacy policies.

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Participant Signature Date

cd: