GAINESVILLE EYE ASSOCIATES
MEDICAL RECORDS RELEASE FORM
770.532.4444 fax:770.535.1852

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR PURPOSES OTHER THAN FOR PAYMENT, TRETMENT AND HEALH CARE OPERATIONS.

_____ _____ _____
Patients Name Date of Birth SS#

_____ _____
Address City State Zip Phone #

I authorize the use and disclosure of the Protected Health Information for the above patient as described.
INFORMATION REQUESTED:

_____ Records for all care at this facility of by this doctor.

_____ Records relating to treatment dates from:_____ to _____

_____ Other (Please Specify)_____

I understand that I have the right to revoke this authorization, in writing, at any time, except

1) Where uses of disclosures have already been made based upon my original permission
2) The authorization was obtained as a condition of securing Insurance coverage and the insurer by has has the right to contest a claim or the Insurance policy.

I understand that the uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocations; this consent will automatically expire 90 days from today's date.
I understand that is is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards.
INFORMATION TO BE RELEASED:

{ }from { }to _____
Name
_____
Street Address
_____
City/State/Zip
_____ _____
Fax # Phone #

{ }from { }to GAINESVILLE EYE ASSOCIATES
2061 BEVERLY ROAD
GAINESVILLE, GA 30501

_____ _____
Signature of Patient/ Legal Guardian Date (auth expired in 90 days)

If this authorization is signed by and individuals personal representative, the representative's authority is based on (e.g., state law, court, etc)