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, TREATMENT 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 or 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)