***AUTHORIZATION FOR USE, RELEASE, OR REQUEST OF YOUR HEALTH INFORMATION***

**Name (print)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Medical Rec#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize the release of medical records TO or FROM (please circle one):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office or Name Mailing Address, including City, State and Zip code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Fax Number

 **Dallas Marietta**

 290 Merchants Square, Suite I 130 Vann Street NE, Suite 230

 Dallas, GA, 30132 Marietta, GA, 30060

 (P) (770) 445-8885 (P) (770) 425-1341

 (F) (770) 428-6484 (F) (770) 425- 8540

**Please list the information you would like released:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care, treatment for alcohol and/or drug abuse, or similar conditions.

The following information should **not** be released, even if occurring during the time frame referenced above:

**Please list the reason for releasing this information**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I understand that this authorization is voluntary. If I do not sign this form, my healthcare from

Cobb Eye Center and the payment of this healthcare will not be affected; however, personal health information may not be released to outside parties, other than for payment, treatment, or business operation.

 I understand that once my information is released, it may no longer be protected by federal privacy regulations.

 I understand that I may see and copy the information described on this form if I ask for it, and I will get a copy of this form after I sign it.

 I understand that this authorization will expire: **upon completion of this disclosure/use**

 I understand that after I sign this form, I may change my mind and revoke this authorization at any time, except to the extent that Georgia Retina has already acted based on the authorization. To revoke this authorization, please notify the office at Marietta or Dallas.

**Signature of Patient or Patient’s Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_**

Printed name of Patient’s Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_