North Fulton Eye Center
Cumming Eye Clinic

AUTHORIZATION FOR USE/RELEASE OF MEDICAL INFORMATION

Step 1: Patient Information

Name: (Print) _____ Date of birth: _____
Last First MI

SS#: (Last 4-digits) _____

_____
Guardian or Authorized Party's Name

Step 2: To whom you wish to release your records

I authorize the use and disclosure of the Protected Health Information for the above named patient as described:
Information Requested:

_____ Copies of all medical records relating to treatment dates _____to _____

_____ Records for all care rendered at North Fulton Eye Center/Cumming Eye Clinic or by our physicians

_____ Other (Please Specify) _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2)the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that 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 expressed revocation; this consent will automatically expire 90 days from today's date. 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.

Information To Be Released ( ) from ( ) to _____

_____

( ) from ( ) to **North Fulton Eye Center**
2500 Hospital Blvd. Suite 115 * Roswell, GA 30076
Office: 770-475-0123 / Fax 770-442-9526

Step 3: Authorization and signature

I have been informed of any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure of my protected health information. I understand that North Fulton Eye Center, PC/Cumming Eye Clinic assumes no responsibility for the use or misuse by others of my protected health information disclosed under this authorization. I release North Fulton Eye Center, PC/Cumming Eye Clinic from all legal liability that may arise from this authorization.

Patient's Signature: _____ Date: _____

Patient Name (Print) _____

If the signature is NOT that of the patient, I acting for the patient because_____

My relationship to the patient _____ **Signature** _____