

Authorization To Release Medical Information

I authorize the named health care provider to release the information or records upon request by mail or facsimile to the address/phone number specified below.

Patient's Name:	
Patient's Social Security #:	
Patient's DOB:	

Dublin Eye Associates Is Requesting Records From The Provider Listed Below	
Provider/Facility Name:	
Provider/Facility Address:	

Records Authorized To Be Released		
<input type="radio"/> Admission History and Physical	<input type="radio"/> Outpatient Surgery Records	<input type="radio"/> Consultation Notes/Reports
<input type="radio"/> Discharge Summary	<input type="radio"/> Lab Report(s)	<input type="radio"/> Diagnostic Testing (OCT, VF)
<input type="radio"/> Office Notes	<input type="radio"/> Radiological Images (MRI, CT)	
<input type="radio"/> Other (specify):		

This Information Will Be Used For The Purpose Of
<input type="checkbox"/> Continue and /or begin treatment as deemed necessary by treating physician <input type="checkbox"/> Provide appropriate referral for treatment as needed <input type="checkbox"/> Other (specify):

Release All Requested Records To
DUBLIN EYE ASSOCIATES 2400 Bellevue Road / 18 Erin Office Park Dublin GA 31021 (phone) 478.272.5933 (fax) 478.272.4350 <i>Glendon W. Smalley, MD / Randall R. Ozment, MD / John G. Williams, MD / Felicia Fountain, MD / Kathryn Falk-Johnson, OD</i>

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 This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing the health care provider, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

- I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal.
 - Federal privacy regulations will no longer apply to the information disclosed, and that Dublin Eye Associates / Vidalia Eye Associates may redisclose the information.
 - I am entitled to receive a copy of this authorization.
 - A copy of this authorization may be utilized with the same effectiveness as an original.
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★ _____
Signature of Patient or Representative

★ _____
Date

★ _____
Print Patient Name or Representative

★ _____
Relationship To Patient