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:	

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

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

This Information Will Be Used For The Purpose Of

- ❑ Continue and /or begin treatment as deemed necessary by treating physician
- ❑ Provide appropriate referral for treatment as needed
- ❑ Other (specify):

Release All Requested Records To

VIDALIA EYE ASSOCIATES
700 Maple Drive
Vidalia GA 30474
(phone) 912.537.1991 (fax) 912.537.1702
Glendon W. Smalley, MD / Randall R. Ozment, MD / John G. Williams, MD / Felicia Fountain, MD / Kathryn Falk-Johnson, OD

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.

★ ______________________________ ★ ______________________________
Signature of Patient or Representative **Date**

★ ______________________________ ★ ______________________________
Print Patient Name or Representative **Relationship To Patient**