

Date of Release

John A. Page, M.D. Malcolm S. Moore, Jr., M.D. Spencer F. Maddox III, M.D. John C. Ervin, M.D. S. Fleetwood Maddox, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The Eye Center of Central Georgia does not release information regarding a patient without their written authorization.

If you would like for our office to release or discuss your medical information with anyone other than yourself, please read and sign below where appropriate.

I hereby request that my medical information be released/discussed with the following: Name Phone Number Phone Number Name Phone Number Name I authorize the above person(s) to discuss the following aspects of my medical information: □ Office Notes □ Billing and Insurance □ Reports from other Physicians □ Lab Reports Patient's Name Date of Birth Zip Code Street Address City State Patient's or Guardian's Signature

Expiration Date