GEORGIA EYE INSTITUTE

Authorization for Release of Medical Records

I authorize Georgia Eye Institute of the Southeast, LLC to release information from the record of:

_____	_____	_____
Patient Name	Birth Date	SSN

_____	_____	_____	_____	_____
Street Address	City	State	Zip Code	Phone Number

to be released to:

_____	_____	_____
Facility/Person to receive records	Phone	Fax

_____	_____	_____	_____
Street Address	City	State	Zip Code

Date(s) of service/time period for information to be released (if left blank, only the last two years will be released):

_____

Information to be released (check all that apply):

☐ All medical records
☐ Office visit notes
☐ Imaging reports
☐ Billing records
☐ Other (please specify): _____

Purpose of Disclosure (fees may apply):

☐ Personal use ☐ Continuity of care ☐ Legal ☐ Insurance
☐ Other: _____

_____ **Right to Revocation**

(initial) I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department of Georgia Eye Institute of the Southeast, LLC. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

_____ **Re-Disclosure**

(initial) I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information, disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

_____ **Fees**

(initial) I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

_____ **Waiver**

(initial) Unless I have indicated otherwise, if the health information that I have requested Georgia Eye of the Southeast, LLC to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as Acquired Immunodeficiency (AIDS), Immunodeficiency Syndrome Related Complex (ARC), Human Immunodeficiency Virus (HIV), Venereal Disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Georgia Eye Institute of the Southeast, LLC and its officers, trustees, agents, and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

_____ **Expiration of Authorization**

(initial) Unless I request in writing otherwise, I understand that this authorization will expire on _____. If I do not specify an expiration date or event, this authorization will expire twelve (12) months from the date on which I signed this authorization.

_____ _____ _____

Signature of Patient (or Patient's Representative) Date Time

__

_____ _____

Printed Name Description of Authority to Act for Patient

This form can be returned to one of the Georgia Eye Institute of the Southeast locations, emailed to mrecords@gaeyeinstitute.com, or faxed to (912) 629-5810.

GEISE Employee Note: A copy of this completed, signed and dated form must be provided to the patient and/or the patient's representative and a copy must be maintained in the patient's medical record.