1415 Wooten Lake Rd. Suite 100
Kennesaw, GA 30144
P. 770-792-3937 F. 770-874-2727

Authorization for Release of Medical Information

Patient Name: _____ DOB: _____

Address: _____

Daytime Phone: _____

I hereby authorize my physician(s) and or staff at: _____,
(fax)_____ to disclose the protected health information described below to:
Name: Tasman Eye Consultants, Address:1415 Wooten Lake Rd., Kennesaw, GA 30144

Information to be released:

_____ All medical records/testing
_____ Medical records on or during date(s):_____
_____ Other: _____

Purpose of Request:

_____ Moving/Relocation
_____ Second Opinion or Provider Change
_____ Patient Request/ For own records
_____ Other: _____

I understand that my records may contain information relating to communicable diseases, mental health conditions, drug or alcohol abuse, Hiv or AIDS, and other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in the above instructions.

I understand that I have the right to revoke the authorization at any time, by sending written notification to the necessary entities. I understand that revocation may not be possible if said information had already been released or during insurance claim processing or claim reviews.

I understand that I do not have to make this authorization. I understand that I may ask for further information if I do not fully understand what information may be disclosed, or that if I do not understand the terms of this disclosure.

Signature of patient (or legal representative): _____

Relationship of legal rep. (if applicable):_____ Date:_____