GEORGIA RETINA

AUTHORIZATION FOR USE, RELEASE, OR REQUEST OF YOUR HEALTH INFORMATION

Name (print):_____ **Medical Rec#** _____

DOB: _____ **Address:** _____

Phone: _____

I hereby authorize the release of medical records TO or FROM (please circle one):

_____ _____

Office or Name Mailing Address, including City, State and Zip code

_____ _____

Phone Number Fax Number

Georgia Retina Fax #:_____ **Georgia Retina Phone # 1-888-427-3846**

Please list the information you would like released:

_____

- I understand that this information may include any history of acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases, human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care, treatment for alcohol and/or drug abuse, or similar conditions.

The following information should **not** be released, even if occurring during the time frame referenced above:

_____

Please list the reason for releasing this information:_____

- I understand that this authorization is voluntary. If I do not sign this form, my healthcare from Georgia Retina and the payment of this healthcare will not be affected; however, personal health information may not be released to outside parties, other than for payment, treatment, or business operation.
- I understand that once my information is released, it may no longer be protected by federal privacy regulations.
- I understand that I may see and copy the information described on this form if I ask for it, and I will get a copy of this form after I sign it.
- I understand that this authorization will expire: **upon completion of this disclosure/use**
- I understand that after I sign this form, I may change my mind and revoke this authorization at any time, except to the extent that Georgia Retina has already acted based on the authorization. To revoke this authorization, please notify the Privacy Officer of Georgia Retina in writing at 833 Campbell Hill St., Ste. 300 Marietta, GA 30060.
- I understand Georgia Retina may charge up to $25 for the reproduction of my medical records based on guidelines from the state of Georgia and the federal government.

_____ _____

Signature of Patient or Patient's Representative **Date**

Printed name of Patient's Representative: _____

Relationship to Patient: _____

Updated 6/30/16