Authorization To Disclose Health Information

Patient Name:

Date of Birth: *S.S. No.:*

1. *I authorize the use or disclosure of the above named individual's health information as described below:*

2. *The following individual or organization is authorized to make the disclosure:*

   North Georgia Eye Care
   72 West Candler Street
   Winder, Ga. 30680
   (770) 867-1913
   Fax: (770) 867-2359

3. *The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)*

   - ❑ *problem list*
   - ❑ *medication list*
   - ❑ *list of allergies*
   - ❑ *most recent history and physical*
   - ❑ *most recent discharge summary*
   - ❑ *any laboratory results ordered*
   - ❑ *consultation reports from (doctor's names)* _____
   - ❑ *entire eye examination/medical record*
   - ❑ *other* _____

4. *This information may be disclosed to and used by the following individual or organization: Dr. Erin M. Jones, O.D. / North Georgia Eye Care for the purpose of reviewing past eye examination/medical records.*

5. *I understand I have the 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 health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the pending of my claim.*

6. *I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure*

treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

7. *You are further authorized to discuss my case in detail with Dr. Erin M. Jones / North Georgia Eye Care or their representatives, and assist them in any way they may request your services.*

8. *I acknowledge receipt of a signed copy of this authorization _____ (Initials)*

_____ _____

Signature of Patient or Legal Representative *Date*

_____

If Signed by Legal Representative, Signature of Witness

Relationship to Patient:_____

A photocopy of this Authorization will be considered as an original.
This Release complies with the HIPAA Privacy Rules