



Patient's Name (Print)

Guardian or Authorized Party's Name (if applicable)

Patient's Social Security Number

Patient's Date of Birth

Phone Number for Authorizing Party

I authorize the use and disclosure of the Protected Health Information for the above named patient as described:

Information Requested:

Records relating to treatment dates from: to:

Records for all care at this facility or by this doctor.

Other (Please Specify)

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire 90 days from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Information to be released [] from [] to

[] from [] to Thomas Eye Group, P.C.

- Alpharetta: 3300 Old Milton Parkway, Suite 125, Alpharetta, GA 30005 (P) 678.287.7640 (F) 404.250.0440
Atlanta: 5671 Peachtree Dunwoody Road, Suite 400, Atlanta, GA 30342 (P) 404.256.1507 (F) 404.256.1981
Atlanta Medical Center: 285 Boulevard NE, Suite 540, Atlanta, GA 30312 (P) 404.582.0096 (F) 404.589.8920
Decatur: 5243 Snapfinger Woods Drive, Suite 101, Decatur, GA 30035 (P) 770.981.9010 (F) 770.593.3461
Lilburn: 3975 Lawrenceville Highway, Lilburn, GA 30047 (P) 770.923.5000 (F) 770.717.9325
Newnan: 2700 Highway 34 East, Building 100, Newnan, GA 30265 (P) 678.423.7700 (F) 678.423.7710
Roswell: 11690 Alpharetta Highway, Roswell, GA 30076 (P) 770.475.5515 (F) 770.343.8884
Woodstock: 149 Towne Lake Parkway, Suite 102, Woodstock, GA 30188 (P) 770.928.4544 (F) 770.928.8609
Surgery Center: 5671 Peachtree Dunwoody Road, Suite 380, Atlanta, GA 30342 (P) 404.705.5757 (F) 678.781.7324

(Initials of patient or legal guardian) I understand that Thomas Eye Group, PC, may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization. A fax copy or photocopy of this consent shall be as valid as the original.

Signature of Patient or Legal Guardian **

Date (Authorization expires in 90 days)

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions, I DO DO NOT authorize the release of this information.

** If this authorization is signed by an individual's personal representative, the representative's authority is based on (e.g., state law, court order, etc.):

FEE SCHEDULE: In accordance with state and federal laws, the following fees may be charged to offset the cost associated with the reproduction of records: Base fee of \$25.88 plus \$.97/page for the first 20 pages; \$.83/page for pages 21-100; and \$.66/page for each page in excess of 100 pages. Records not kept in paper form (e.g., photos or computerized reports) will be charged at the cost of their reproduction. Actual cost of postage incurred in mailing records will be added.

For office use only:

Manager's Authorization Date sent: By: