To request medical records, please fill out the following form in its entirety. Send the completed form back to the Thomas Eye Group address provided below. If you have any questions, please call us at
678-892-2020 and ask to speak with the health information department.

Thomas Eye Group, PC
Attn: Health Information Department
5901-A Peachtree Dunwoody Road
Suite 500
Atlanta, GA 30328
Fax:678-538-1950

Information for patients:

- **Due to the large number of requests, processing is performed by an outside vendor.**
- **Since requests are now processed offsite patients will no longer have the ability to pick up their records in person.**
- **Requests are processed as they are received. This includes records being sent to another physician, referring physician, insurance companies, and patients. If the records are needed for immediate care the request will be expedited on a case by case basis and sent only to the provider.**
- **In cases where someone other than the patient is requesting the records, proper documentation may be required by state and federal law to allow the release of personal health information.**
- **Failure to completely fill out the form in its entirety may result in a delay of your records being processed. In order to maintain HIPAA complaince we must have an intended use for the records, and the exact information you would like must be written on the form.**

Please allow two weeks for medical records to be sent out. However, please be aware that federal and state law allows healthcare providers 30 days to respond to written requests for records. Thank you for your patience.

PHI DISCLOSURE AUTHORIZATION

Thomas Eye Group, P.C.

Patient's Name (Required; please print) ____________________

Guardian or Authorized Party's Name (if applicable) ____________________

Patient's Date of Birth (Required) ____________________

Phone Number for Authorizing Party ____________________

ALL INFORMATION INSIDE THIS BOX IS REQUIRED

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.

Please release information FROM:
[ ] Thomas Eye Group, P.C.
[ ] Other: ____________________

____

Please send the information TO:
[ ] Thomas Eye Group, P.C. Fax: 678.538.1950
5901A Peachtree Dunwoody Rd Ste 500; Atlanta, GA 30328
Attn: Medical Records
[ ] Other (name and send-to information required): ____________________

____

Intended use/purpose for releasing information: ____________________

_________ **(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)

__________ (**Initials of patient or legal guardian)** 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 CDs) will be charged at the cost of their reproduction. Actual cost of postage incurred in mailing records will be added.

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.): ____________________