To request your previous Buddy Russell or Michael Ward medical records, please fill out the following form in its entirety. Send the completed form back to theThomas Eye Group address provided below. If you have any questions, please call us at
678-781-7306 and ask to speak with Crystal.

Thomas Eye Group, PC
Attn: Crystal
5901-A Peachtree Dunwoody Road
Suite 500
Atlanta, GA 30328
Fax:678-673-3712

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: _____

__X__ Records for **all care** at this facility or by this doctor. Michael and/or Buddy's complete chart

__X__ Other (Please specify) Xcel Specialty Contacts for contact lens parameters.

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.
[X] Other: Emory Eye Center and Xcel Specialty Contact Lenses

_____

Please send the information TO:

[X] 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: Continuation of Care

_____ **(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.): _____