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 offsite and can no longer be picked up 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.

Thomas Eye Group, P.C.

PHI DISCLOSURE AUTHORIZATION

*Indicates a required field

Patient Name (Please Print)*

Guardian or Authorized Party's Name (If Applicable)*

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: (*Please select one of the following)

_____ 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 form 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. Attn: Medical Records
5901-A Peachtree Dunwoody Road, Suite 500, Atlanta, GA 30328
Fax: 678-538-1950

( ) Other:

***Intended Use/Purpose for Releasing Information:**

_____(Initials of patient or legal guardian) I understand that Thomas Eye Group, P.C. 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.

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.

Signature of Patient or Legal Guardian** Date

**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.)