Augusta Office:
1330 Interstate Parkway
Augusta, GA 30909
706- 651-2020 Fax 706- 855-6674

Aiken Office:
792 Silver Bluff Rd
Aiken, SC 29803
803-642-9902 Fax 803-642-8611

Authorization to Receive / Release Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal or state privacy regulations. I authorize Eye Physicians and Surgeons of Augusta, P.C. to disclose the following information from the medical record of:

Patient Information

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip_____

Phone Number _____ Cell Phone Number _____

Covered Entity to Receive Information:

Name: _____

Address: _____

Phone number: _____ Fax number: _____

I would like my records: ☐ faxed or mailed to entity above ☐ picked up ☐ send to patient portal

☐ Emailed to: _____

Covered Entity to Release Information:

Name: _____

Address: _____

Phone number: _____ Fax number: _____

The Information Below Will Be Used For: ☐ Patient Care ☐ Other _____

_____ Complete Medical Record, including any that may exist concerning:

☐ Mental health care or services ☐ Communicable disease
☐ Treatment for alcohol and/or drug abuse ☐ Photographs, videotapes, digital or other images
☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection

_____ Medical Records for Specific Dates of Service (please list) from _____ to _____.

_____ Other (please list)_____

Rights of the Patient

- I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above.
- I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward
- I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Any information received by this office for own use will continue to be protected by the Federal Privacy Rule.
- I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification.
- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
- Eye Guys, its employees, officers, and physicians are hereby release from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____ _____

Printed Name of Patient or Personal Representative | Signature of Patient or Personal Representative | Date

_____

Description of Personal Representative's Authority (attach necessary documentation)

This authorization shall be in effect for one year from the date signed.