West Georgia Eye Care Center

# Medical Records Release

Authorization for the Release or Disclosure of Protected Health Information

**1. Patient Name** (please print): _____ Date of Birth:_____

Acct. Number: _____ Address:_____

City: _____ State:_____ Zip Code:_____ Phone: _____

*I authorize the disclosure of specific health information from the records of the above-named patient as indicated below.*

☐ Released By: ☐ Received By: West Georgia Eye Care, 2616 Warm Springs Rd, Columbus, GA 31904

☐ Released By: ☐ Received By: Name:_____

Address: _____City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

**2. Description of health information disclosed:**

☐ Complete Medical Record (specify dates of service) _____

OR

☐ Partial Medical Record (specify records and dates of service below)

| Information | Dates | Information | Dates |
|---|---|---|---|
| ☐ Lab Results | _____ | ☐ Op Report | _____ |
| ☐ History & Physical | _____ | ☐ Billing History | _____ |
| ☐ Progress Notes | _____ | ☐ Other | _____ |
| ☐ Consult Notes | _____ | ☐ Other | _____ |

**4. Expiration of Authorization:** Unless I request in writing otherwise, I understand that this authorization expires on: _____. If I do not specify a date, this authorization will expire 90 days from the date of signature.

**5. Re-disclosure:** I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

**6. Release and Waiver:** If the health information that I have requested contains any privilege psychiatric or psychological information related in the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as AIDS/HIV, Aids-Related Complex, Venereal Disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release WGMA and/or the releasing facility checked above, and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims, which might arise from the release of the health information authorized by me above.

_____ _____

Signature of Patient (or representative) Date

_____

Relationship of Patient Representative

2616 Warm Springs Rd, Columbus, GA 31904
(P) 706-323-3491 (F) 706-660-9191