

**MARIETTA EYE CLINIC, PA
895 Canton Road, Bldg 100, Marietta, GA 30060
Phone (678)784-0219 / Fax (678) 784-0254**

**Authorization for Disclosure of Patient's
Medical Records (PHI))**

	<input type="checkbox"/> Being Released Patient's Medical Records <input type="checkbox"/> Being Requested or
Patient's Full Name	
Patient's DOB	
Address	
Phone Number	

	<input type="checkbox"/> Releasing Records Third Party <input type="checkbox"/> Receiving Records or
Name of Entity or Person	
Contact Person	
Address	
Phone Number	
Fax Number	

By signing this authorization, I authorize Marietta Eye Clinic PA & Cherry Street Optical, Inc., hereafter known as Marietta Eye Clinic (the "Practice") to use and/or disclose certain protected health information (PHI) to or for the party or parties listed in above table.

A. What PHI may be used or disclosed: This Authorization permits the Practice to use or disclose the following PHI:

[Specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.].

B. Describe the specific purpose(s) for which you authorize the Practice to use or disclose this PHI:

[Must include each purpose of the requested Use or Disclosure, but may state: "at the request of the individual" if the individual is initiating the Authorization and does not, or elects not to, provide a statement of the purpose]

C. This authorization will expire on the date of _____.
[Specific expiration date or expiration event must be inserted, but the statement "end of research study" or "none" may be used if the Authorization is for a use or disclosure of PHI for research].

D. I understand that when my PHI is disclosed pursuant to this Authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing, except (i) to the extent that the Practice has acted in reliance upon this Authorization; or (ii) to the extent that the Authorization was obtained as a condition of obtaining insurance coverage, there is other law that grants the insurer the right to contest a claim under the policy. I understand that my revocation must be submitted in writing to the Practice's Privacy Official/Committee at **895 Canton Road, Bldg 100, Marietta, GA 30060** by sending a written request stating that I wish to revoke this Authorization to the attention of the Privacy Official/Committee.

I understand that the Practice may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Signed by: _____ Date _____
Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative: _____

If signed by a Personal Representative, please state such person's authority to act for the Individual: _____

NOTE: PATIENT OR PERSONAL REPRESENTATIVE MUST BE GIVEN A COPY OF THIS AUTHORIZATION