AUTHORIZATION FOR **RELEASE** OF MEDICAL RECORDS

MILAN EYE CENTER

Patient Name: _____ D/O/B: _____

I, _____ authorize Milan Eye Center to use or disclose a copy of my medical records as identified below to (name/address/phone/fax): _____

_____

for the following purposes:

☐ Continuing Care & Treatment ☐ Insurance Claim ☐ Legal ☐ Personal Use

☐ Other, describe: _____

By initialing the spaces below, I specifically authorize the use and disclosure of the following health information and/or medical records, if such information and/or medical records exist:

_____ Discharge Summary/Discharge Note _____ Examinations _____ Consultation Reports

_____ Progress Notes _____ Physician Orders _____ Laboratory Reports

_____ Diagnostic Imaging Reports _____ Entire Medical Record

_____ Other, describe: _____

I understand that if the person or entity receiving the information is not a health care provider or health care plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I understand that the person I am authorizing to use or disclose the information may receive compensation for doing so. I may inspect or copy any information to be used or disclosed under this authorization. Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signature or until _____.

_____ _____

Signature of Patient or Patient's Legal Representative Date

_____

Print Name of Patient

_____ _____

Print Name of Patient's Legal Representative Relationship

_____ Patient is unable to sign authorization but gives verbal approval for the use or disclosure of health information as described in this authorization.

Reason patient is unable to sign: _____

Cataract, Corneal, Refractive, and MIGS Surgery

Milan Patel, M.D.
Niraj Desai, M.D.
Samir Vira, M.D.
Cameron Johnson, M.D.
Vandana Reddy, M.D.
Manuel Chaknis, M.D.
Justin Needham, M.D.
Sagar Patel, M.D.

Reconstructive and Aesthetic Oculofacial Plastic Surgery

Kiran Sajja, M.D.
Sagar Patel, M.D.

Optometry

Charlie Ficco, O.D.
Kate Lohman, O.D.
Erica Shah, O.D.
Christopher Easley, O.D.
Elizabeth C. Denneny, O.D.
Farzana Virani, O.D.
Aimee Mesenburg, O.D.

Johns Creek
Cumming
Canton
Buford
Marietta
Alpharetta
Snellville

PREFERRED EYE CARE PARTNER OF THE **ATLANTA BRAVES**