

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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 Notes ___ 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 take 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

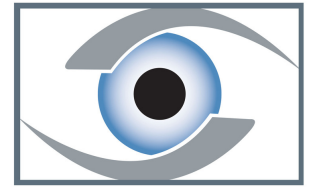
Print Name of Patient

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: _____



MILAN
EYE
CENTER

Cataract, Corneal Refractive, and MIGS Surgery

Milan Patel, M.D.
Niraj Desai, M.D.
Samir Vira, M.D.
Cameron Johnson, 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. Denny, 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

