AUTHORIZATION FOR **RELEASE** OF MEDICAL RECORDS

Patient Name: _____ D/O/B: _____

I, _____ request and authorize _____ to release or disclose a copy of my medical records as identified below to Milan Eye Center, faxed to 678-381-2020 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, expect 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.
Aldo Espinoza, 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.
Erica Bridges, O.D.
Brittany Moates, O.D.

Johns Creek
Cumming
Canton
Buford
Marietta
Alpharetta
Snellville

PREFERRED EYE CARE PARTNER OF THE ATLANTA BRAVES