

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, 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

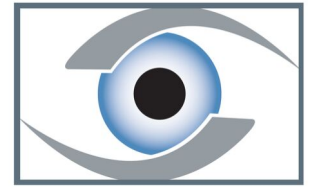
Print Name of Patient

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: _____



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. Denny, 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

