MILAN EYE CENTER

OFFICE: **678.381.2020** FAX: **678.381.2015**

ALPHARETTA | BUFORD | CANTON | CUMMING | DAWSONVILLE | JOHNS CREEK | MARIETTA | SNELLVILLE

AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

I, _____ request and authorize _____

to release or disclose a copy of my medical records as identified below to Milan Eye Center, **faxed to 678-381-2015** or mailed to **Medical Records Dept., 1034 Haw Creek Circle, Cumming, GA 30041** 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
___ Diagnostic Imaging Reports	___ Progress Notes	___ Physician Orders
___ Laboratory 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

_____

Patient's name (PLEASE PRINT)

_____ _____

PRINT Name of Patient's Legal Representative Relationship