Authorization To Disclose Health Information

Patient Name:

Date of Birth: S.S. No.:

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

   Dr. Cara Robison, O.D.

   North Georgia Eye Care

   72 West Candler Street

   Winder, Ga. 30680

   (770) 867-1913

   Fax: (770) 867-2359

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ❑ problem list
- ❑ medication list
- ❑ list of allergies
- ❑ most recent history and physical
- ❑ most recent discharge summary
- ❑ any laboratory results ordered
- ❑ consultation reports from (doctor's names) __________________
- ❑ entire eye examination/medical record
- ❑ other ____

4. This information may be disclosed to and used by the following individual or organization: Dr. Cara Robison, O.D. / North Georgia Eye Care for the purpose of reviewing past eye examination/medical records.

5. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will

not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the pending of my claim.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

7. You are further authorized to discuss my case in detail with Dr. Cara Robison / North Georgia Eye Care or their representatives, and assist them in any way they may request your services.

8. I acknowledge receipt of a signed copy of this authorization _________ (Initials)

_______________________________________ _________________

Signature of Patient or Legal Representative Date

____

If Signed by Legal Representative, Signature of Witness

Relationship to Patient:_________________________

A photocopy of this Authorization will be considered as an original.
This Release complies with the HIPAA Privacy Rules