



P: 478-744-1710
F: 478-259-4503
4050 Riverside Dr.
Macon, GA 31210
visioneyegroup.com

David W. Boone, D.O.
Jeffery C. Hinson, Jr., M.D.
Kinsey P. Watkins, O.D.
J. Stephen Ellis, M.D.
William H. Jarrard, Jr., M.D.
Dennis P. Breene, M.D.
J. Michael Simmons, Jr. O.D.
Misti S. Smith, O.D.

Authorization to Release Medical Records

Release records and information regarding:

(Patient's Name)

(Date of Birth)

(Telephone Number)

(Address, City, State, Zip Code)

I hereby authorize the disclosing physician or health care provider noted below to release medical information to the receiving physician or health care provider indicated. The following information should be furnished: Medical records, operative reports, visual field testing, glaucoma flow charts, optic nerve photography, OCT studies, IOL power measurements, laboratory studies, x-ray reports, MRI and CT scanning reports.

FROM: _____

Physician/Practice Information

TO: Vision Eye Group 4050 Riverside Drive, Macon, GA 31210 Fax: 478-259-4503

As the patient/legal guardian signing this authorization, I understand that I am giving my permission for my confidential health information to be released. The health information will be released to the recipient by fax when a fax number is provided. If no fax number is provided the records will be mailed to the address listed above unless other arrangements are specified.

DURATION:

This Authorization shall become effective immediately and shall remain in effect through _____ (enter date) or for one year from the date of signature if no date is entered. I understand that this form may be revoked at any time with written consent.

REDISCLASURE:

I understand that the requestor may not lawfully further use or disclose the health information unless another Authorization is obtained from me or unless the disclosure is specifically required or permitted by law.

This form has been fully explained and I certify that I understand its contents.

Signature of Patient Date