Atlanta Ophthalmology Associates, P.C.

5730 Glenridge Drive, Ste. 120
Atlanta, GA 30328
Phone: 404-252-1194 Fax: 404-252-1196
www.aoaeye.com

# AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ________________________________ Last 4 digits of SSN:___________

Previous Name, if applicable: ________________________________________________

Address: _______________________________________________________________

_____________________________________________________________________

Date of Birth: ___/___/___ Home Phone: ____________ Email address: ______________

I authorize representatives from the following to disclose the health information as directed below:

____ 1. Atlanta Ophthalmology Associates, 5730 Glenridge Drive NE, Ste. 120
Atlanta, GA 30328 Phone: 404-252-1194 Fax: 404-252-1196

____ 2. Dr. Office Name: ___________________________________________________
Address: ________________________________________________________
Phone: ___________________ Fax: ___________________

**Please send my health information to:**

____ 1. Myself: *please circle* address above *OR* fax:_________________

____ 2. Atlanta Ophthalmology Associates, 5730 Glenridge Drive NE, Ste. 120
Atlanta, GA 30328 Phone: 404-252-1194 Fax: 404-252-1196

____ 3. Dr. Office Name: ___________________________________________________
Address: ________________________________________________________
Phone: ___________________ Fax: ___________________

**Please include the following records:**

____ from (dates of service) _______ to _______

____ Most Recent Exam and medical testing

____ Complete Medical Records

This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification or cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations.

____________________________________________ ______________________
Patient or Guardian Signature Date