Advanced Family Eyecare
"PROVIDING A CLEARER VISION OF YOUR FUTURE"

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
FOR PURPOSES OTHER THAN FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS

_____ _____
Patient's Name (Please Print) Guardian or Authorized Party's Name (If Applicable)

_____ _____ _____
Patients Social Security Number Patient's Date of Birth Patient's Phone Number

I authorize the use and disclosure of the Protected Health Information for the above named patient as described:
Information Requested:

_____ Records relating to treatment dates from: _____ to: _____
_____ Records for all care at this facility or by this doctor.
_____ Other (Please Specify): _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses of disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocations, this consent will automatically expire in 90 days from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Information to be Released:

[ ] From [ ] To _____
Name
_____
Address
_____ _____
Phone Number Fax Number

[ ] From [ ] To **Advanced Family Eyecare, LLC**
4320 Suwanee Dam Rd., Suite 2100
Suwanee, GA 30024
Phone: 770-614-8577 Fax: 770-614-8509

_____ **(Initials of patient or legal guardian)** I understand that Advanced Family Eyecare, LLC may not condition my treatment on my signing this authorization and that I have the right to refuse to sign this authorization. A fax copy or photocopy of this consent shall be as valid as the original.

_____ _____
Signature of Patient of Legal Guardian** Date (Authorization expires in 90 days)

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse, or psychological/psychiatric conditions,
I (DO // DO NOT) authorize the release of this information.

**If this authorization is signed by an individual's personal representative, the representative's authority is based on (e.g., state law, court order, patient is a minor child, etc.): _____

FEE SCHEDULE: In accordance with state and federal laws, the following fees may be charged to offset the cost associated with the reproduction of records: Base fee of $25.00 plus $0.90/page for the first 20 pages, $0.80/page for pages 21-100, and $0.65/page for each page in excess of 100 pages. Records not kept in paper form (e.g. photos or computerized reports) will be charged at the cost of their reproduction. Actual cost of postage incurred in mailing records will be added.

FOR OFFICE USE ONLY:
Doctor/Manager Authorization:_____ Date Sent: _____ Sent By: _____