SOUTHERN VITREORETINAL ASSOCIATES, P.L.

☐ H. Logan Brooks, Jr., M.D. ☐ Robert L. Steinmetz, M.D. ☐ Charles K. Newell, M.D.
☐ Christopher L. Willingham, M.D. ☐ Emily D. Ashmore, M.D. ☐ Nicholas C. Farber, M.D. ☐ Daniel R. Richardson, M.D.

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Patient Name:____ DOB:___________________________

Address:____

COST OF REPRODUCING MEDICAL RECORDS
(Allow 10 days for request to be processed)
A $1.00 per page up to 25 pages and .25 per page afterward. All photos are $2.50 each. Records on CD are $10.00.

THIS WILL AUTHORIZE:
Agency/Representative:____

Address:____

to release general medical information as well as information concerning AIDS, HIV, ARC (AIDS-related complex), along with the performance of any tests, counseling, and the results and treatment there of. The releasing agent is authorized to act on behalf of a copy/facsimile of the original form.

THE SPECIFIC INFORMATION REQUESTED IS:

( ) *Clinical Exam Notes*
( ) *Test Results: IVFA, ICG B-scan, A-scan, Fundus Photos*
( ) *Surgery Summary*
( ) *Procedure Notes*: *Photocoagulation, Cryopexy, Surgery*
( ) *Medical History Summary*
( ) *Other*: ________________________
____

THIS INFORMATION IS TO BE RELEASED TO:
Agency/Representative: ____

Address: ____

FOR THE PURPOSE OF:
( ) Legal Issues
( ) Continuity of Care
( ) Coordination of Treatment
( ) Other: ________________
____

THIS INFORMATION MAY BE RELEASED (Please check all that apply):
( ) Written (i.e., copies) ( ) Fax

THIS AUTHORIZATION IS FOR disclosure of information from ______________to_____________. This authorization may be revoked at any time upon written notification by the signatory or client, but revocation has no effect on action previously taken.

Signature of Patient or Patient's Guardian or
Empowered Representative:*____ Date:________________

*(IF AN AUTHORIZED SIGNATURE IS NOT ON FILE, FORM MUST BE NOTARIZED. LEGAL PAPERS MUST ACCOMPANY RELEASE IF CLIENT IS A MINOR OR UNABLE TO SIGN.)

Signature of Witness:____ Date:________________

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records protected by federal confidentiality rules (42CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

TO BE VALID THIS FORM MUST BE FILLED OUT COMPLETELY

2439 Care Drive
Tallahassee, FL 32308
850-942-6700 or 800-940-1225
Fax: 850-942-5735

2709 Meredyth Drive, #220
Albany, GA 32707
229-889-8300 or 866-473-8462
Fax: 229-889-1192

2577 Huntcliff Lane
Panama City, FL 32405
850-763-7007 or 800-940-1225
Fax: 850-763-7002

3563 North Crossing Circle
Valdosta, GA 31602
229-316-0207 or 800-940-1225
Fax: 229-316-0210

200 12 Street West, Suite F
Tifton, GA 31794
229-386-0297 or 800-940-1225
Fax: 229-388-6569

210 East Lamar Street
Americus, GA 31709
800-940-1225
Fax: 850-942-5735

555 Byron Butler Parkway
Perry, FL 32347
800-940-1225
Fax: 850-942-5735