EFFINGHAM
EYE CARE
6162 Highway 21 South * Rincon, Georgia 31326
(912) 826-3949 Phone * (888) 810-2083 Fax

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____ to release information from the medical records of:

PATIENT NAME:_____

DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER:_____

Please release the following information:

_____

ENTIRE MEDICAL RECORD

Purpose for information:

_____

TRANSFER OF CARE

Please release these records to the offices of Dr. Sarah Freeman and Dr. Kerry Freeman.

This consent will expire ninety (90) days after the day below, of sooner at my election. This authorization may be revoked, but not retroactively, to the release of information made in good faith.

_____ _____

Patient Signature **Date**

ANY DISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.