

Allatoona Eye Institute, PC
962 J. F. Harris Parkway, Suite 201
Cartersville, GA 30120
(770) 382-3598

MEDICAL RECORDS/X-RAY RELEASE AUTHORIZATION

TO--->

DOCTOR / HOSPITAL _____

ADDRESS _____

CITY STATE ZIP _____

I Hereby authorize and request you to release to.....
Jeffrey R. Brant, MD, and Feng Zhao, MD, PhD at the address listed above, the following medical information

- | | |
|---|--|
| <input type="checkbox"/> Complete records | <input type="checkbox"/> Ophthalmology related records |
| <input type="checkbox"/> X-rays, | <input type="checkbox"/> CAT & MRI scans |
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Nuclear Scans |
| <input type="checkbox"/> Biopsy results | <input type="checkbox"/> Pathological slides |
| <input type="checkbox"/> All of the above | |

Note: Special Dates of Interest _____ to _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment.

Patient Name _____

SS# _____ Date of Birth _____

Address _____

City State Zip _____

Signature _____ DATE _____

Witness _____