Georgia Ophthalmologists

Authorization for Use and Disclosure of Protected Health Information

I hereby authorize Georgia Ophthalmologists, LLC to use and/or **receive / disclose** my protected health information as described below **to / from**

Patient Name: _____ DOB: _____ Phone number: _____
Address: _____

Purpose of release: _____

☐ Check here if Georgia Ophthalmologists is requesting your medical records from another physician.
(We will request records to be faxed to 770-385-0813)

I authorize the release of medical information as indicated below:

☐ I would like records sent via email to: _____.
** Please note, sending information via email is unencrypted and could expose your Protect Health Information (PHI) to security risks. The practice does take all measures possible to transmit any PHI in a secure format. I understand that in requesting information to be sent in this format, that I am releasing Georgia Ophthalmologists, LLC. from all liability and security risks associated with sending any PHI via email.
☐ I would like to pick up a copy of my records in the following format (circle): Hardcopy Disk
☐ I would like records faxed to: (please indicate fax #) _____
☐ I would like records mailed to the address listed below in the following format (circle): Hardcopy Disk

Marketing:

☐ If this box has been checked by the practice, I understand that the practice will receive compensation for using or disclosing my information for marketing purposes.

Type of Information to Be Disclosed

☐ Entire Medical Record ☐ Office Chart Notes ☐ Billing Statements ☐ Operative Reports
☐ Other _____

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Georgia Ophthalmologists, LLC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) Georgia Ophthalmologists, LLC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Medical Records Retrieval Rates (if applicable): https://dch.georgia.gov/medical-records-retrieval-rates

Search, Retrieval and Other Direct Administrative Costs (Effective July 1 2019)		$25.88
Certification Fee	Up to Per Record:	$9.70
Copying Costs for Records in Paper Form	Per page for pages 1-20:	$0.97
	Per page for pages 21-100:	$0.83
	Per page for pages over 100:	$0.66

Patient/Representative Signature: _____ Date: _____

Patient Representative (Print): _____ Relationship: _____
(Please note, a patient representative must be listed on the patient's chart or have power of attorney letter to receive records)

Expiration:
This authorization will expire 180 days from the date of signing or **(insert date)** _____.

OFFICE USE ONLY

Received and identity verified by (print and sign): _____ Date: _____