Chart: _________

1909 Honeysuckle Road Suite 2   Dothan, AL 36305

(334) 699-7100 Phone   (334) 699-7410 Fax

Authorization for Release of Information

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then released information may no longer be protected by federal regulations.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on actions taken before the revocation.

The Specific information released will be the discretion of Southern Eye Specialists dependant on continuation of care and coordination of care.

If there is a specific organization that you request we receive records from, please indicate here:

This medical record may contain information about drug abuse, alcoholism, alcohol abuse, HIV testing and/or AIDS treatment as well as other sensitive medical issues. Separate consent must be given before this information is released. You can elect to not share this information. Please initial here to indicate your consent: ___________

Patient Name (Please Print):____ Date: ________________

Social Security Number: _________________________________ Date of Birth :_______________________

Signature of Patient or Guardian: ____