AUTHORIZATION FOR RELEASE

OF MEDICAL RECORDS

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Facility

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code

You are hereby authorized to release all medical records, x-ray reports, lab reports, medical history, and all other information to:

Auburn Cataract and Eye Clinic, LLC

785 N. Dean Rd, Suite 100

Auburn, AL 36830

Fax-334-887-2030

For the following purpose or need: Transfer of Records of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name (PRINT) Date of Birth

It is understood that this authorization is revocable except to the extent that action has been taken in reliance thereon, and this authorization will remain in force but, not to exceed on year, in order to effectuate the purpose for which it was given. Auburn Cataract and Eye Clinic, LLC is released from all legal responsibilities that may arise from this act.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Patient’s Signature

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date