Mount Vernon Eye Care, P.C.
Dunwoody Opticians, Inc.

1611 Mount Vernon Road, Dunwoody, GA 30338
Phone 770-393-0003 ♦ Fax 770-393-1557

Authorization for Use or Disclosure of Medical Records

_____ _____
Date Patient Name (please print)

_____ _____ _____
D.O.B. Last 4 # of SSN Telephone #

I, _____, authorize **Mount Vernon Eye Care, P.C., Dunwoody Opticians, Inc.** and its authorized agents and employees to use and/or disclose the minimum necessary protected health information of my medical records **currently maintained by**:

_____
Name of the facility

_____
The name of doctor/facility/person requesting the medical information

_____
Mailing address, telephone and/or fax # of where records to be sent to

I do not authorize further release to any other third party. I understand that Mt. Vernon Eye Care, P.C., Dunwoody Opticians, Inc. and its staff, employees, officers and directors cannot be responsible for confidentiality of information disclosed after said information had been released pursuant to this authorization, and hereby release them from any liability arising from such disclosure and from legal responsibility or liability that may arise from this authorization. I understand that I may revoke this authorization at any time and that upon fulfillment of the above stated purpose or lapse of twelve (12) months from the date of signature, whichever comes first, this authorization will automatically expire without my express revocation, but that revocation may not be applied retroactively once the information has been released in good faith.

Patient's signature: _____ or

Person authorized to sign for patient: _____

Relationship to patient: _____