



*Kathleen C. Leone, MD, FACS*

*Matej Polomsky, MD*

*Christopher D. Covington, DO*

*Alan E. Oester, Jr., MD, FACS*

*Travis C. Jenkins, MD*

*Melissa G. Shipley, MD, FAAP*

*Amanda B. Baden, OD*

*Travis L. Pickens, OD*

*Leann L. Geerts, OD, FAAO*

*Hilary B. Cox, OD*

**Authorization for Disclosure of Health Information**

1. Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Telephone \_\_\_\_\_

Address \_\_\_\_\_

2. I am requesting that my records be sent FROM: \_\_\_\_\_  
(Dr./Medical Facility)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

3. Please send records TO: \_\_\_\_\_  
(Dr./Medical Facility/Self)

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

4. Reason for request (optional): \_\_\_\_\_

5. Covering the period of healthcare from \_\_\_\_\_ to \_\_\_\_\_

6. I understand this could include information about AIDS, HIV, behavioral or psychiatric care, alcohol or drug abuse.

7. I understand that this authorization may be revoked in writing at any time.

8. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information.

|                                |       |
|--------------------------------|-------|
| <u>Please provide records:</u> |       |
| Electronically                 | Paper |

9. Please allow several business days for processing.

Signed: \_\_\_\_\_  
(patient) (date)

\_\_\_\_\_ or (legal representative) (relationship to patient) (date)

\_\_\_\_\_ (signature of witness) (date)