



EFFINGHAM

EYE CARE

6028 Highway 21 South * Rincon, Georgia 31326
(912) 826-3949 Phone * (888) 810-2083 Fax

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____ to release
information from the medical records of:

PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

Please release the following information:

_____ **ENTIRE MEDICAL RECORD** _____

Purpose for information:

_____ **TRANSFER OF CARE** _____

Please release these records to the offices of Dr. Sarah Freeman and Dr. Kerry Freeman.

This consent will expire ninety (90) days after the day below, of sooner at my election.
This authorization may be revoked, but not retroactively, to the release of information
made in good faith.

Patient Signature

Date

ANY DISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT(S) IS PROHIBITED
EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.