Southpoint Eye Care, P.C.
Clifford R. Seward, M.D.
5900 Hillandale Drive, Suite 345
Phone: 678 990-4480
Fax: 678 990-4481

Authorization for Use or Disclosure of Protected Health Information

PATIENT NAME_____
LAST **FIRST** MI

DATE OF BIRTH: _____/_____/_____SS#:_____MEDICAL RECORDS#: _____

_____
ADDRESS **CITY** **STATE** **ZIP**

☐ **I authorize my protected health information to be released to Southpoint Eye Care, P.C. as indicated below:**

_____
Name of entity to release this information

_____
ADDRESS **CITY** **STATE** **ZIP**

_____
Phone Number **Fax Number**

Information To Be Released:

□ All eye records
□ Second opinion
□ X-ray reports
□ Other

Purpose Of Disclosure:

□ Changing physicians
□ Legal
□ Continuing care
□ At patient request

This authorization expires at the earlier of _____OR the date the following event occurs.

I understand that I may revoke this authorization at any time by notifying Southpoint Eye Care, P.C. in writing. This authorization will cease to be effective on the date notified except to the extent that the Practice has acted in trust upon this authorization.

_____ _____
Signature of Patient or Legal Guardian **Date**

C Effective September 1, 2004
Revised April 1, 2016