SOUTHPOINT EYE CARE
5900 HILLANDALE DR., SUITE 325B
PRIVACY OFFICIAL: GWEN WARE
LITHONIA, GA 30058
PHONE: 678 990-4480
FAX: 678 990-4481

Authorization for Use or Disclosure of Health Information

Patient Name: _____

Patient's Date of Birth: _____ Patient's SS#_____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Specific Description of the Information to be Used or Disclosed Including (If Practicable) the Dates of Service(s) Related to Such Information:

_____
_____

The above information will be called "Authorized Information" throughout the rest of this form.

Persons or Practice Where Records Are Being Requested From:

_____
_____

Persons or Practice Where Records Are Being Sent To:

DR. CLIFFORD R. SEWARD/SOUTHPOINT EYE CARE
_____

Authorized Information will be used and/or disclosed for the following purposes:

___ At the request of the individual (check box if applicable)
___ Other (Please list each purpose of the use(s) or disclosure(s) in the space provided:

_____
_____

$ I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be

protected by federal or state law.

$ I understand that I may revoke this authorization at any time by notifying SOUTHPOINT EYE CARE in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by SOUTHPOINT EYE CARE before receiving my revocation.

$ I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

$ (ALTERNATIVE, IF APPLICABLE: I understand that SOUTHPOINT EYE CARE may require me to sign an authorization prior to receiving research-related treatment or treatment solely for the purpose of creating health information for another party and that SOUTHPOINT EYE CARE will not provide such research-related treatment unless I provide this authorization**. NOTE:** If this provision is applicable, the third party for whom the information is being created must be listed under "Persons or Class of Persons to Whom the Use or Disclosure of Authorized Information May be Made." Also, the purpose for which the information is to be created and disclosed must be listed under "Authorized Information will be Used or Disclosed for the Following Purposes."

$ (FOR MARKETING AUTHORIZATIONS ONLY, IF APPLICABLE) I understand that the person or entity I am authorizing to use and/or disclose Authorized Information for marketing purposes may receive either direct or indirect compensation for doing so.

This authorization expires _____

Signature of Patient or Patient's Personal Representative: _____

Date:_____

For Personal Representative of the Patient (if applicable):

Print Name of Personal Representative:_____

Describe Personal Representative Relationship/Authority to Act for the Individual (parent, guardian, etc):_____