REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: ______________________________

DOB: ____________________

Please release the following records:

☐ All ☐ Other: ______________________________

☐ TO: ☐ From: ______________________________

Name of Physician

____

Street Address

______________ ________ ________

City State Zip Code

______________ ______________

Phone Number Fax Number

☐ TO: ☐ From: Children's Eye Institute of Savannah, Inc.
John M. DeVaro, M.D.
340 Eisenhower Drive
Bldg. 1400, Suite A
Savannah, GA 31406
(912)353-1001 Fax: (912)353-1026

I understand that some of the health information contained in the medical records described above may be confidential and cannot be disclosed without my written authorization. I also understand that the specified information to be released may include but is not limited to past medical history, diagnoses, mental illness, treatment of drug or alcohol abuse, and/or communicable diseases. I am aware that any information used or disclosed above may be disclosed by the recipient and no longer be protected by the Privacy Rule. I hereby waive any privilege or confidentiality existing under Federal or State law.

I request that my medical records be released as stated above.

______________________________ ______________

Signature of Patient/Guarantor Date

______________________________ ______________

Witness Date