WOODHAMS Eye Clinic

6105 Peachtree Dunwoody, Building A, Suite 100, Atlanta, GA 30328
770-394-4000 (p) 770-913-0841 (fax)

Records Release Authority

I, _____ hearby request that you release to:

Doctor: _____

Address 1: _____

Address 2: _____

City _____ State _____ Zip Code _____

Due to the following reasons:

☐ I am moving and need to transfer records

☐ I am getting a second opinion

☐ I am getting my records for my personal use

☐ I am changing doctors and need to get my medical records mailed to my new doctor

A report of my diagnosis, treatment, prognosis, and recommendations, as well as other data pertinent to your treatment of me

From:_____

Date of Request: _____

Patient Date of Birth: _____

Patient Address: _____

City _____ State ___ Zip Code _____

Patient Phone Number _____

Patient Signature _____Doctor Signature _____

☐ Emailed ☐ Faxed ☐ Mailed

*Please Allow 7-10 business days for your medical records to be processed upon receipt of consent form to our office. We will send records doctor-to-doctor as a courtesy at no charge. Charges will also apply for patients requesting records for more than one doctor. Patients will be charged an administration fee of $25 and $0.66 per page for copies of personal records.