SOUTH GEORGIA
NORTH FLORIDA
eye partners

Authorization for Use and Disclosure of Protected Health Information

By law medical information is confidential unless written authorization is given. Therefore, upon signing this form, I, ___________________________________, am authorizing SOUTH GEORGIA | NORTH FLORIDA EYE PARTNERS, PC to release medical information to:

Name	**Relationship**
____	__________________________
____	__________________________
____	__________________________
____	__________________________
____	__________________________

This authorization is valid as of _____ / _____ / _____, the date I signed below. This remains in effect until I give notification to discontinue.

____

Patient Name

____

Patient Signature

____ __________________________

Parent or Guardian Signature (if patient is a minor) Relationship

____

Date