huffmanfamilyeyecare

80 Seven Hills Blvd.
Bldg 200
Dallas, GA 30132

Phone: 678-324-4211 *Fax*: 678-324-4216 *Text*: 678-324-4216

Email: mail@huffmaneye.com

Dr. Peter Huffman *Dr. Kim Vazquez* *Dr. Tyler Lebel*

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below

Print Patient Name: _____ DOB: _____

The information you may release subject to this signed release form is as follows:

- ☐ Medical Records
- ☐ Billing Records

This medical release form

- ☐ Terminates on _____ or
- ☐ Does not Terminate

Release My protected information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: _____ DOB (if applicable): _____

Address: _____ State _____ Zip Code _____

Phone Number: _____

Signed: _____ Date:_____/_____/_____
(Patient or Legal Guardian)