



**AUTHORIZATION FOR PATIENT RECORDS**

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PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

I hereby authorize **GEORGIA EYE PARTNERS** to release any information obtained in the course of my examination and treatment to:

SELF/DOCTOR'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

PHONE NUMBER \_\_\_\_\_

DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_

WITNESS \_\_\_\_\_

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COMPLETED ON \_\_\_\_\_

**Please Fax back to:  
Georgia Eye Partners  
404-829-1319**

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T: (404)-531-9988

**Emory Midtown**  
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