AUTHORIZATION FOR PATIENT RECORDS

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Gagan Sawhney, M.D.
Josh Johnston, O.D.
Natalie Eads, O.D.
Sarah Bassett, O.D.

PATIENT NAME:___________________________________ DOB:____________

I hereby authorize:

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To release any information obtained in the course of my examination and treatment to:

Georgia Eye Partners- Please fax back to 404-829-1319

DATE__________________ SIGNATURE__________________________

WITNESS____________________________

FOR OFFICE USE ONLY:
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