WOODHAMS
Laser & Lens Implant Center

6105 Peachtree Dunwoody Rd Bldg A, Ste 100 Atlanta GA 30328
P-(770) 394-4000 F-(770) 913-0841

RECORDS RELEASE AUTHORITY

I, _____ Hereby request that you release to:

Doctor: _____
Address 1 _____
Address 2 _____
City _____ State _____ ZIP _____

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 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 _____
Patient Phone Number: _____

Patient Signature _____ Doctor Signature _____

Released and Copied by: _____ Date: _____

- ☐ E-mailed
- ☐ Faxed
- ☐ Mail

Please allow 7-10 business days for medical records to be processed upon receipt of consent form to our office.

ITEM	Patient FEE
Administration Fee	$25.00 per record
Per page copying:	$0.66 per page
Certification of copies of patient's record	$9.70 per record
Postage	Actual cost
Records sent or faxed to other doctor	No charge