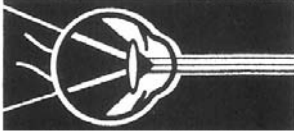

Charles S. Hill, M.D., P.C.
4171 Snapfinger Woods Dr., Decatur, GA 30035-3412
Phone: (404) 284-8288
Fax: (404) 284-0557
E mail: info@HillsEyeClinic.com

Incoming Medical Records from other Physicians

I authorize representatives from the following facility/facilities to disclose the health information as directed below:

Doctor/Hospital ____
Address ____
City ____________________ State ____________ Zip ______
Phone # ______________________ Fax # ____________________

I hereby authorize the release of my medical records or copies of such, from my initial examination to final examination, and request that they are transferred to:

Charles S. Hill, M.D.
4171 Snapfinger Woods Drive
Decatur, GA 30035-3412

Phone: (404) 284-8288
Fax: (404) 284-0557
e mail info@hillseyeclinic.com

Patient Name __________________________ SS# _______________________
DOB ___/___/___ Previous Name, if applicable __________________________
Address _______________________________ City ______________ State ___
Zip ______________ Home Phone _______________ Work Phone _____________

_________________________________ _______________
Signature of Patient (or Patient's Representative) Date

____
Description of Authority to Act for Patient

Date Faxed ____________ Date Mailed _______________