Authorization for Release of Information

Patient Identification

Printed Name: _____ Date of Birth: _____

Address: _____ SSN:_____
(Street Address)

_____ Telephone: _____
(City) (State)

Information is to be released by:

_____
(Physician or Facility)

_____
(Street Address)

_____
(City, State, and Zip Code)

_____
(Phone #) (FAX #)

Information to be sent to:

_____
(Individual/Agency/Facility)

_____
(Street Address)

_____
(City, State, and Zip Code)

_____
(Phone #) (FAX #)

Information To Be Released-Covering the Periods of Health Care

From (date) _____To (date) _____

Please check type of information to be released:

( ) Complete health record ( ) Pathology Report ( ) Radiology Report
( ) Laboratory test results ( ) Complete billing record ( ) EKG Report
( ) Other (specify) _____

Purpose of Request

( ) Treatment or consultation ( ) At the request of Patient
( ) Billing or claims payment ( ) Other (specify) _____

I understand that my medical or billing record may contain information in reference to mental health or psychotherapeutic treatment, alcohol or drug testing or treatment, and HIV/AIDS confidential information.

One Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, you have the right to revoke this Authorization by submitting a notice in writing to Alpharetta Internal Medicine to whom you are authorizing disclosure. Unless revoked, this Authorization will expire on the following date or event _____,
Or 90 days from date of signature, unless otherwise specified.

Medical Release **I understand that this authorization is voluntary.**

I understand the information released pursuant to this Authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The practice, its employees, officers and physicians are hereby released from legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

Our provider will not deny treatment if you do not sign this form. You may inspect or copy your protected health information. **By signing now, you authorize your provider, identified above, to release your protected health information specified above.**

_____ _____
Signature of Patient or Representative **Date**

_____ _____
Print Name **Relationship of Representative to Patient**

PLEASE DESCRIBE THE REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF THE PATIENT

_____

_____