

**Authorization for Release of Information TO:**

FAMILY PRACTICE CENTER PC

993 Johnson Ferry Rd, Bldg F, Ste. 210 Atlanta, GA 30342 Phone: 404.256.1727 Fax: 404.252.3591

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

LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ SS#: \_\_\_/\_\_\_/\_\_\_ ACC#: \_\_\_\_\_

MO DY YR

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DAY PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_

**I HEREBY AUTHORIZE:**

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

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ EMAIL: \_\_\_\_\_

**TO RELEASE INFORMATION FROM MY MEDICAL RECORD AS INDICATED BELOW TO:**

NAME: FAMILY PRACTICE CENTER PC

ADDRESS: 993 JOHNSON FERRY RD, STE. 210, BLDG F CITY: ATLANTA STATE: GA ZIP: 30342

PHONE: 404.256.1727 FAX: 404.252.3591

**INFORMATION TO BE RELEASED:**

- HISTORY AND PHYSICAL EXAM(S)
- PROGRESS NOTE
- LAB REPORTS
- X-RAY REPORT
- OTHER: \_\_\_\_\_

DATES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I specifically authorize the release of information relating to:

- Substance abuse (including alcohol/drug abuse)
- Mental Health (including psychotherapy notes)
- HIV related information (AIDS related testing)

X \_\_\_\_\_  
SIGNATURE OF PT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE:  Changing physicians  Consultation/second opinion  Continuing care  Legal  
 School  Insurance  Workers Compensation

Other (please specify): \_\_\_\_\_

1. I understand that this authorization will expire on 365 days after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by Family Practice Center PC for the purpose of:

- a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
- b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
- c. I have been informed that Family Practice Center PC  will/ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with Georgia statute, I will pay a fee of \$ \_\_\_\_\_ There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

\_\_\_\_\_  
SIGNATURE OF PATIENT DATE OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

\_\_\_\_\_  
RECORDS/REQUEST RECEIVED BY DATE OR RELATIONSHIP TO PATIENT DATE