Authorization for Release of Information FROM:

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: 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

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

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____ EMAIL: _____

INFORMATION TO BE RELEASED:

	DATES:
o HISTORY AND PHYSICAL EXAM(S)	_____
o PROGRESS NOTE	_____
o LAB REPORTS	_____
o X-RAY REPORT	_____
o OTHER: _____	_____

I specifically authorize the release of information relating to:

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

X _____ _____
SIGNATURE OF PT OR LEGAL GUARDIAN DATE

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

o 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 o will/o 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.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ OR _____ _____
RECORDS/REQUEST RECEIVED BY DATE RELATIONSHIP TO PATIENT DATE