Authorization for Release of Information

TO: FAMILY PRACTICE CENTER

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____/_____/_____ SS#: _____/_____/_____ MRN: _____

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

PRIMARY PHONE: _____ PHONE TYPE: ☐ CELL ☐ HOME ☐ OTHER: _____

I HEREBY AUTHORIZE _____
(Practice name & address)

PHONE: _____ FAX: _____

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

Name: **FAMILY PRACTICE CENTER · 993 JOHNSON FERRY RD, NE, F210 · ATLANTA · GA · 30342**

Phone: **404-256-1727** Fax: **404-252-3591** Email: **MR@FAMILYPRACTICECENTERPC.COM**

INFORMATION TO BE RELEASED: **DATES**

☐ HISTORY AND PHYSICAL EXAM(S) _____
☐ PROGRESS NOTES _____
☐ LAB REPORTS _____
☐ X-RAY REPORTS _____
☐ OTHER _____
_____

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 PATIENT 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 _____ 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 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 statue, 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 OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____
RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY
MR REQ RECEIVED BY: _____ DATE: _____
DATE REQUEST FULFILLED: _____ BY: _____
PAYS ADMIN SERVICE FEE: _____ FEE COLLECTED: $_____