Authorization for Release of Information
FROM: 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:

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

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

NAME: ____

ADDRESS: ______________________________ CITY: ____________________ STATE: _________ ZIP: ______________

Phone: ________________________ Fax: ________________________ Email: ______________________________

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: $______________________