Authorization for Release of Information

From: Family Practice Center

Patient Name: _____

Date of Birth: _____/_____/_____ Phone Number: _____

I hereby authorize:

Family Practice Center
993 Johnson Ferry Rd, NE, F210, Atlanta GA 30342
P: 404-256-1727 F: 404-252-3591 Email: medicalrecords@familypracticecenterpc.com

To release my medical records to:

Practice Name: _____

Phone Number: _____ Fax/Email: _____

Information to be released:	Dates:
☐ ALL	☐ ALL
☐ History and Physical Exams	_____
☐ Progress Notes	_____
☐ Lab Reports	_____
☐ Xray Reports	_____

I understand this may include the release of information relating to:

Substance Abuse (including alcohol/drug abuse)

Mental Health (including psychotherapy notes)

HIV related information (AIDS related testing)

Purpose of Disclosure:

☐ Changing Physicians ☐ Consultation/Second opinion ☐ Continuing care ☐ Legal
☐ School ☐ Insurance ☐ Workers Compensation ☐ Other (specify) _____

1. I understand that this authorization will expire 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. By authorizing this release of information, my health care and payment for my healthcare will not be affected if I do not sign this form.
5. 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.
6. I have been informed that Family Practice Center PC will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
7. I understand that in compliance with Georgia statute, I will pay a fee of $7.50 if I do not pay the administrative service fee. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____

Signature of Pt or parent/legal guardian/authorized person Date

Relationship to patient:_____

For Office Use:

MRN:_____ Records to another provider? Y / N If no, Pays ASF? Y / N
If no, Fee Collected ($7.50)? Y / N