2451 Cumberland Parkway, Suite 3535

Atlanta, GA 30339

Office Phone : 770-434-0042 Office Fax: 888-501-4110

Authorization for Release of Information

Patient Name: DOB: Last 4 Digits of SSN:

Address: City State Zip

Home Phone: Day Phone: Email:

Reason for Disclosure: _____

I authorize the following facility/physician to release my records:

Name:_____

Address:_____

Please release the following items noted below from my medical record:

__Progress Notes __Radiology/Ultrasound Reports __Complete Medical Record

__Lab Results __Operative Report __Other:_____

Receiving Party & Method of Delivery: __ Mail (Complete info below) __Email (Please provide email above)
__Fax (required for continued care requests.)

Name:

Address:

Fax #: **necessary if going to another Doctor.

Fees For Personal Copying Costs: **1-15 pages: $5.00 plus postage** **16-50 pages: $25.00 plus postage**
51-100 pages: $35.00 pages plus postage **101+pages: $50 plus postage.**

_____I understand that a fee for copying medical records may be incurred.

____I understand that this authorization will include any medical records including HIV records, psychiatric or alcohol abuse records and any other statutory protected disease unless otherwise stated so. This authorization and consent will expire 60 days following the date signed. I understand I may revoke this authorization at any time to the extent that action has previously taken in reliance hereof.
(Please check both to acknowledge.)

Signature: Date: