1348 Walton Way, Suite 4100
Augusta, GA 30901

465 N. Belair Road, Suite 1B
Evans, GA 30809

706-722-1381 ~ (Fax) 706-823-6871

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please print information. All information must be completed in entirety prior to releasing/obtaining records.

Patient's Name _____ DOB _____
Last First M/I

Address _____

City _____ State _____ Zip _____

Treatment date(s) From _____ to _____(only records from these dates will be released)

( ) Release my records to: ( ) Obtain my records from:

Name of Entity _____

Attn: _____ Phone Number: _____

Address _____

City _____ State _____ Zip _____

Purpose of Release of Records: _____

Description of information to be released:
( ) All records for above dates ( ) Pregnancy records ( ) Bone Density report(s) ( ) Mammogram report(s) ( ) Pap Smear report(s)

( ) Other (specify) _____

I understand that these medical records may or may not contain information pertaining to psychiatric counseling or testing, alcohol or drug abuse counseling or testing, and/or HIV/ARC testing, I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity(ies) as stated above. This authorization/consent will remain in effect for a period of one (1) year from the date stated below, unless revoked in writing by the person to which it pertains (or his/her parent, legal guardian or legally authorized agent), to the Medical Records Department. These medical records are being disclosed under the provisions of the applicable New Jersey State and Federal Law.

NOTICE TO THE RECEPIENT OF RECORDS: The information has been disclosed to you from records protected by Federal Laws of confidentiality (42 C.F.R. Part 2). These laws prohibit you from making any further disclosure of these records, unless further disclosure is expressly permitted by written authorization by the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of these medical records is not sufficient for this purpose. You may only use these medical records for the purpose(s) as stated above.

_____ _____
Signature of Patient or Date
Personal Representative (as defined by HIPAA, attach personal representative authority form)

****

Office use only: Receiving employee: _____ Date Received: _____