AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ Social Security No._____

Address _____ Date of Birth _____

City, State, Zip _____

Home/Cell Phone _____ Work Phone _____

I authorize the below named provider to disclose the health information as directed below by fax or by mail to the address specified below.

Provider Name: _____ Phone Number: _____

RECORDS AUTHORIZED TO BE RELEASED:

__ Office Notes (complete medical record)
__ Outpatient records
__ Psychiatric and other mental health records
__ Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)
__ Lab reports
__ Radiological images (x-rays)
__ Consultation notes or reports
__ HIV and/or AIDS related information
__ Other_____

PLEASE SEND MY HEALTH RECORDS TO:

KELLY RICH FAMILY MEDICINE
1215 Eagles Landing Parkway, Suite 211
Stockbridge, GA 30281
Phone 470-878-6912/Fax 470-878-1849

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the healthcare provider, but that revoking this authorization will not affect disclosures made or actions taken before revocation is received.

I also understand that:

- I am not required to sign this authorization and that my healthcare or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that may redisclose the information.
- A copy of this authorization may be utilized with the same effectiveness as an original.

_____

PATIENT OR REPRESENTATIVE (PLEASE SIGN) DATE

_____

NAME OF REPRESENTATIVE (PLEASE PRINT) RELATIONSHIP TO PATIENT