AUTHORIZATION TO RELEASE INFORMATION

Patient: Name ____ Date of Birth ____________________
Address ____ Social Security#______________________
City ________________________________ State ______ Zip code ____________________
Day Phone Number ___________________________ Email address _________________________________

Clinic: Information to be released to:
Name ____
Address ____
City ___________________________________ State _______ Zip Code __________________________
Fax____________________________________

Recipient: Information to be released from:

(**Alpharetta**)	**(South Forsyth)**
9995 Jones Bridge Road	**4330 Johns Creek Pkwy. Ste 300**
Alpharetta, GA 30022	**Suwanee, GA 30024**
(770) 475-1242	**(770)-232-7844**
FAX (770) 475-1032	**(770)-232-9455**

Information to be disclosed: Medical Record Release Date of Service Requested _________________

☒ Clinic Visit Notes
☐ Special Tests ______________________
☐ Consultation/Follow-up Reports
☐ Immunizations
☐ Occupational Health/Worker's Comp
☐ X-Ray Report/Mammography Report
☐ Lab Reports
☐ X-Ray Films
☐ Hospital Reports
☐ Optical
☐ Mental Health/Psychological Testing/Reports
☐ Other __________________________________
☐ All the above (including records relating to HIV, alcohol, drug treatment, records relating to communicable disease and/or those marked confidential).

**Information in your chart that was not originally generated by this clinic will not be released to another facility. Such information must be obtained from the original source.*

Reason for Release:
☐ Legal
☒ Consult/Second Opinion
☐ Insurance Claim Report
☐ Insurance Changed to ____
☐ Out of Town Move
☐ Selected New Physician
☐ Referred by Dr. ___________________________________

Revocation: I understand that I may revoke this consent at any time and that the consent will automatically expire twelve months from the date of my signature.
I do not authorize further release to a third party. I understand that once information is released under this authorization, clinic and their employees and my physician(s) cannot prevent the redisclosure of that information.

Authorization: I authorize the above provider to release the information marked above to the recipient,

______________________________________ Signature of Patient/Guardian

____ Relationship to Patient if signed by Guardian

______________________________________ Date of Patient's Signature

____ Reason Patient Unable to Sign

Records Copied: Date ____________________ By Whom ___________________________________

Medical Record Copies will be: Mailed ________________ Picked Up ____________