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 from:
Name ____
Address ____
City __________________________________ State _______ Zip Code ____________________________
Fax___________________________________

Recipient: Information to be released to:

(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 ____________