Georgia Infectious Diseases, PC
5673 Peachtree Dunwoody Rd NE, Suite 600 · Atlanta, Georgia 30342
Phone: (404) 256-4111 · Fax: (404) 256-0040

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Medical Records Release / Request Form

Patient Name: _____
(Last, First, Middle)

Date of Birth: _____ Telephone number: _____

Address: _____

_____

Reason for Record Request: _____

Release Records

☐ **FROM** *Georgia Infectious Diseases, PC* **TO**: ☐ **TO** *Georgia Infectious Diseases, PC* **FROM**:

_____
(Name)

_____
(Address)

_____
(City, State, Zip)

_____
(Phone Number) (Fax Number)

I hereby authorize the release of photocopies of the following medical records in the possession of the above-named facility, its employees and/or agents. For the purpose hereof, "medical records" shall include all confidential HIV-related information (as defined in A.R.S. Section 36-61), confidential communicable disease-related information (as defined in A.R.S. Section 36-661), confidential alcohol or drug abuse related information (as defined in 42 CFR section 2.1 et seq.), and confidential genetic testing and mental health diagnosis/treatment information (as defined in A.R.S. Section 12-281).

Information to be released (for the last 1 year if available):

___ Office Notes ___ Laboratory Results ___ Vaccine Records ___ All Medical Records
___ Other Records (specify) _____

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Georgia Infectious Diseases, PC based upon this authorization. I may not be able to revoke this authorization if it purpose was to obtain insurance. Once health care information is disclosed, the person of organization that receives it may re-disclose it. Privacy laws may no longer protect it. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

This authorization expires within twelve (12) months from the date signed. If you wish to have the authorization expire before twelve (12) months, please indicate the date of expiration: _____.

It is further understood that there may be a fee, payable by the patient, for releasing these records.

_____ _____
Signature of Patient or Legal Surrogate **Date** **Time**

_____ _____
Printed Name of Patient or Legal Surrogate **Relationship (If Legal Surrogate)**