



Doctors you can trust. Care you deserve.

NORTH GEORGIA
WOMEN'S
CENTER

Authorization for Release of Medical Records

Patient Name (Please Print) _____

Date of Birth _____ SSN _____ Phone Number _____

I hereby authorize (physician's office) _____ Phone/Fax # _____

To disclose records obtained in the course of my evaluation and/or treatment to:

_____ Phone/Fax # _____

Disclosure will include: (check all that apply) All Dates: _____

History & Physical Lab Reports Operative Reports Radiology Reports

Progress/Physician Notes Pathology Reports Other: _____

Exclude the following: (indicate by initialing) I understand that by initialing these records will NOT be sent.

___ Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse.

___ Records of HIV testing and/or AIDS diagnosis or treatment.

___ Psychiatric, psychological records or evaluation and/or treatment for mental health, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

I also understand the following:

- I have the right to limit the type of information released. If I choose to limit the information released, I understand it may be necessary for my health care provider to inform the requester that portions of the records have been withheld.
- This authorization shall remain valid unless revoked but will expire 1 year after signing. This contest is subject to written revocation by the undersigned at any time except to the extent that action has already been taken.
- My health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above.

Signature of Patient or Substitute Decision Maker

Date

If Substitute Decision Maker, state relationship

If Substitute Decision Maker, state reason

Reason for Request:

Moving out of state

No Insurance

New Patient

Personal Records

Transferring Care

Reason:

PRACTICE CLOSING

Method of Disclosure:

Mail to above patient address Hand delivered to patient

Mail to above provider Faxed to above provider

Signature of Completer

Date

Patient Acknowledgement of Receipt of Hand Delivered Records:

Signature

Date