Primary Care Group of West Georgia
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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient information:

Name:_____ Age:__ DOB:_____ SS#:_____

Address: _____

Who has the information you would like to release? (Health care facility provider)

Name:_____ Phone#:_____ Fax#: _____

Address:_____ City:_____ State:___ Zip:_____

To whom should the information be sent: (Requestor)__

Name:_____Phone#:_____Fax#:_____

Address:_____ City:_____ State:___ Zip:_____

Information to be disclosed:

__Medical record dated: _____ to _____

___Last 3 Office Notes and RECENT Labs, Diagnostic Reports, and Discharge Summary from last hospital admission.

Include records regarding HIV status: (initial) Yes____ No____

Reason For Release:

__Out of town move __Consult/second opinion __ Selected new physician

__Personal __Other: _____

Revocation:

I understand that this authorization will be in effect for 12 months, unless cancelled by me in writing. I understand that the information used or disclosed may be subject to re-disclosure by facility or provider receiving, and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Primary Care Group in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me whether or not I sign the authorization. Fees for copies: Federal and state laws permit a fee to be charged for copying of the patient records. You will be required to pre-pay for the copies. Initial: _____

Authorization:

I authorize the provider listed above to release the information marked and send to the requestor.

Patient Signature:_____

Patients Printed Name:_____ Date:_____

If other than patient signing, please state relation to patient:_____

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