**PRIMARY CARE GROUP OF WEST GEORGIA, PC**
Joseph Jellicorse, MD ◦ Hermogenes Pagsisihan, MD,
Jeffery Reid, MD ◦ Lindsey Roenigk, MD ◦ Angela Pham, MD
**Elizabeth Scholl, PA-C ◦ Cristal Rush, NP-C ◦ Melanie Sims, NP-C ◦Savannah Jackson, NP-C ◦ Lauren Holcombe, NP-C**

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**Patient information:**

Name:_____ Age:___DOB:___ SS#:_____

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

**Who has the information that you would like to release? (Healthcare facility or provider)**

Name:_____ Phone#:_____ Fax#: _____

Address:_____ City:_____ State:____ Zip:_____

**Send the health information to: (Requestor)_____**

Primary Care Group of West Georgia
100 Professional Park, Suite 204
Carrollton, Ga. 30117
PHONE 770-834-3351 - FAX 770-830-1518

**Attention: _____**

**Information to be disclosed:**

__Medical records 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 __ Recommendation __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 the receiving facility or provider and may 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 their 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: _____