TANNER PRIMARY CARE OF CARROLLTON
TANNER RHEUMATOLOGY SPECIALIST
TANNER MEDICAL CENTER, INC.
905 DIXIE STREET
CARROLLTON, GA 30117
PHONE 770-812-5831
FAX 770-812-5832

REQUEST AND AUTHORIZATION TO RETRIEVE MEDICAL INFORMATION

(PROTECTED HEALTH INFORMATION)

I do hereby authorize Physicians Care Group of West Georgia, PC to disclose information or copies thereof covered under privacy regulations issued pursuant to the HIPPA Act of 1996 to Tanner Medical Center, Inc. or any of its affiliated entities and subsidiaries pertaining to the care and treatment of (Patient Name)_____
D/O/B _____from (Date) 9/1/2015 through (Date) 11/30/18.

This consent and authorization includes, for the period indicated, the care and treatment records designated pertaining to the patient for physical and/or emotional illness including psychological or psychiatric treatment and/or alcohol and drug abuse, and/or AIDS (HIV) related testing or illness, and/or testing for sexually transmitted diseases. The nature and extent of the information to be released is:

Patient identification data	Operative report	Imaging reports	Image films
Abstract only	Clinical notes	Laboratory reports	Film category
ED report	Physician orders/notes	EKG/EMG report	Cardiac Cath video
History/Physical	Physical therapy notes	Complete record	Discharge Summary
Respiratory therapy notes	Other: RHEUMATOLOGY MEDICAL RECORDS AND ALL SUPPORTING DOCUMENTS		

The requested use or disclosure of this medical information is: continuation of care

I HEREBY ACKNOWLEDGE AND UNDERSTAND THAT THIS AUTHORIZATION IS A WAIVER OF THE CONFIDENTIAL AND PRIVILEGED NATURE OF THE RECORDS DESIGNATED ABOVE BUT ONLY WITH RESPECT TO THE SPECIFIED PURPOSE(S) FOR WHICH THIS DISCLOSURE IS MADE. I FURTHER ACKNOWLEDGE AND UNDERSTAND THAT THIS AUTHORIZATION Will PREVENT THE PATIENT FROM MAKING CLAIM FOR A VIOLATION OF PRIVACY IN CONNECTION WITH THE RELEASE OF THE MEDICAL INFORMATION AS DESCRIBED HEREIN. I UNDERSTAND THAT TANNER MEDICAL CENTER, INC. CANNOT REQUIRE ME TO SIGN THIS AUTHORIZATION IN ORDER TO RECEIVE TREATMENT UNLESS THE PROVISION OF HEALTHCARE IS SOLELY FOR THE PURPOSE OF' CREATING ,PHI FOR DISCLOSURE TO A THIRD PARTY (EX. EMPLOYEE PHYSICAL EXAM) OR FOR RESEARCH RELATED TREATMENT, IN WHICH TANNER MEDICAL CENTER, INC. WILL-NOT PROVIDE THE SERVICE UNLESS I SIGN THIS AUTHORIZATION.

THIS REQUEST AND AUTHORIZATION MAY BE REVOKED AT ANY TIME BY WRITTEN NOTICE RECEIVED BY TANNER MEDICAL CENTER, INC'S HEALTH INFORMATION MANAGEMENT DEPARTMENT, BUT ANY REVOCATION WILL NOT APPLY TO RECORDS ALREADY FURNISHED IN RELIANCE UPON THIS REQUEST AND CONSENT. THIS REQUEST SHALL REMAIN VALID UNTIL REVOKED, OR UPON THE EXPIRATION OF ONE HUNDRED EIGHTY (180) DAYS, WHICHEVER OCCURS FIRST

_____ _____ _____

(Signature Of patient or legal representative) (Relationship) (Date)

Persons Authorized to Consent to Release of Medical Information

1. Any adult for self (18 years or older)
2. Any parent for his/her minor child
3. A guardian for his/her ward
4 Next of kin for disabled patient unable to sign for self, or Executor or Administrator of an estate for the sole purposes of obtaining payment for services from a third party payer in connection with an insurance claim.