Premier Internal Medicine of Alpharetta, PC

Authorization to Disclose/Transfer Health Information

Name of Patient _____ DOB: _____ Date: _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record (s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR:

___Continuing Medical Care ___Military ___Social Security/Disability

___Insurance ___Personal Use ___Other

___Legal Purposes ___School

INFORMATION TO BE RELEASED OR ACCESSED:

___History & Physical ___Consultation Report ___Emergency Room Notes

___Operative Report ___Discharge Summary ___Diagnostic Tests

___Lab/Path Report ___Radiology/Imaging ___Office Notes

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The above information be released **TO**:

Premier Internal Medicine of Alpharetta, PC
3665 Old Milton Parkway, Suite 30, Alpharetta, GA 30005
678-369-6993 (phone) / 866-292-0442 (fax)

FROM: (Please list name, address, phone and fax numbers.)

_____

_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specified information to be released may include, but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV/AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire one (1) year from the date of my signature unless I revoke the authorization prior to that time.

I understand that information released pursuant to the authorization may be subject to re-release by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. The practice, its employees, officers, and physicians are hereby released from legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

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Signature of Patient or Guardian Printed Name of Patient or Guardian Relationship to Patient