

Premier Internal Medicine of Alpharetta, PC
Authorization to Disclose/Transfer Health Information

PATIENT INFORMATION:

Name of Patient: _____ DOB: _____
Address: _____ Phone #: _____

PROVIDER RELEASING INFORMATION:

Name of Practice/Provider: _____ Phone #: _____
Address: _____ Fax #: _____

RECIPIENT OF INFORMATION (*Who will receive the records*):

Premier Internal Medicine of Alpharetta, PC
Dr. Kira Colbert
3400 Old Milton Parkway, Suite C585, Alpharetta, GA 30005
678-369-6993 (phone) / 866-292-0442 (fax)

INFORMATION TO BE RELEASED (*check all that apply*):

Entire medical record Billing/Insurance records Medication List Immunization Records
 History & Physical Consultation Report Hospital/Emergency Room Notes Operative Report
 Discharge Summary Diagnostic Tests Office Notes Lab/Path Report Radiology/Imaging
 Other: _____

PURPOSE OF DISCLOSURE:

Continuing Medical Care Military Social Security/Disability Insurance
 Personal Use Other Legal Purposes School

SENSITIVE INFORMATION (*Initial if applicable*)

TIME PERIOD OF RECORDS:

I specifically authorize release of information relating to: _____ From _____ to _____

- Mental health records _____ (or) All available records
- Substance use treatment _____
- HIV/AIDS or STD information _____
- Genetic information _____

PATIENT RIGHTS

- I understand I may revoke this authorization in writing at any time.
- I understand that once released, information may no longer be protected by HIPAA.
- I understand that treatment, payment, or eligibility for benefits is not conditioned on signing this authorization.

SIGNATURE:

Patient or Legal Representative Signature: _____ Date: _____

Printed Name: _____ Relationship: _____