AUTHORIZATION FOR RELEASE OF INFORMATION

TO: Southeastern Primary Care Specialists
105 Carnegie Place, Suite 103
Fayetteville, Ga 30214
OR
1035 Southcrest Drive, Suite 200
Stockbridge, Ga 30281

PHONE: (770) 716-7999
FAX: (770) 716-8444

PHONE: (770) 716-7999
FAX: (770) 716-8444

FROM:_____
ADDRESS:_____
_____
PHONE:_____
FAX:_____

PATIENT:_____
ADDRESS:_____
_____
PHONE:_____
DOB:_____

I hereby authorize the above named provider to release to Southeastern Primary Care Specialists the following information:

____ Provider's summary of diagnosis, medications, treatments, prognosis, and recent care

____ Admission/Operative/Discharge Summaries

____ Immunization History

____ Laboratory/Pathology Reports

____ Diagnostic Imaging

Dates of Services _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquire immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition_____. If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164524. I understand that any disclosure of information carries with it the potential for an unauthorized re disclosure and the information may be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative (Guardian or Authorized Representative must attach documentation of such status)

Date

_____ _____

Printed Name of Authorized Representative

Relationship/Capacity to Patient