Premier Internal Medicine of Alpharetta, PC

Authorization to Disclose/Transfer Health Information

Name of Patient _____ Date _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical records (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 (Echo, Stress Test, EGD, ect.)

___Lab/Path Report ___Radiology/Imaging ___Office Notes

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The above information be released **TO**:

Premier Internal Medicine, 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 and 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.

_____

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

Date: _____