PIEDMONT
INTERNAL
MEDICINE

Authorization to Release Medical Records

Patient Name_____ **MRN/SSN**_____

Date of Birth_____ **Phone # (best reached)** _____

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

Information Needed for:

☐ Continuing Medical Care ☐ Personal

☐ Insurance ☐ School

☐ Legal Purpose ☐ Disability/SSA/FMLA

☐

_____ Other: (please specify) _____

Information to be Released or Accessed: ☐

☐ History and Physical ☐ Consultation Report

☐ Operative Report ☐ Discharge Summary

☐ Lab/Pathology Report ☐ Radiology Report

☐ ER Record Face Sheet _____

Other: (please specify) _____ **The**

above information may be released to:

Piedmont Internal Medicine/Dr. _____ _____ *Phone: 404-351-7467*

Address: 3280 Howell Mill Road NW Suite 150, Atlanta, GA 30327, Fax: 404 -350-0754

Requesting Records:

FROM: _____ Phone: _____

Address: _____ Fax: _____

Disclose Protected Health Information to the following persons:

Name: _____ Phone Number: _____

Name: _____Phone Number: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but it 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 this authorization. The authorization will expire in six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

DATE: _____

Signature: _____ _____

(Patient/Legally Authorized Representative)