



Authorization for Release/Disclosure of Medical Information

Please **REQUEST** Medical Information **FROM:**

Please **SEND** Medical Information **TO:**

Eagles Landing Family Practice Imaging Center

 Name of Medical Office/Hospital

 Street Address

 City, State and Zip Code

 Phone Number/Fax Number

 Name of Medical Office/Hospital

1100 Hospital Drive
 Street Address

Stockbridge, GA 30281
 City, State and Zip Code

678-432-6161 678-432-3677
 Phone Number/Fax Number

I hereby authorize _____ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

 Full Name of Patient

 Address

 Date of Birth

 State

 Telephone Number

 Zip Code

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature if no date entered.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Redisclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Specify Records to be Released/Disclosed: (check which information is to be released/disclosed)

- General Medical Information** (from _____ to _____)
- Mammogram Films/Reports** (from _____ to _____)
- X-Ray** (check one or both): **Films** **Reports**
- Laboratory Results**
- Mental Health** (from _____ to _____)
- Alcohol/Drug** (from _____ to _____)
- HIV Test Results** (from _____ to _____)
- Other** (specify): _____

_____ Signature of Patient	_____ Date
_____ Signature of Patient	_____ Date
_____ Signature of Patient	_____ Date

I request that the health information released/disclosed pursuant to this authorization be used for the following purposes only: Review of Medical Records

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.

_____ Date	_____ Signature of Patient or Representative	_____ Relationship to Patient
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