EAGLES LANDING HEALTH
Providing care at your convenience.

Email Form To:
medicalrecords@elfp.com

Authorization for Release/Disclosure of Medical Information

Please **REQUEST** Medical Information **FROM**:	Please **SEND** Medical Information **TO**:
	ELH Medical Records Department
Name of Medical Office/Hospital	Name of Medical Office/Hospital
	3333 Riverwood Pkwy SE, Ste 250
Street Address	Street Address
	Atlanta, GA 30339
City, State and Zip Code	City, State and Zip Code
	(770) 914-0116 (678) 826-5911
Phone Number/Fax Number	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	Date of Birth	Telephone Number
Address	State	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; <u>If not specified 2 years will be provided by default</u>)

- ☐ **General Medical Information** (from_____to_____)
- ☐ **Information Regarding Specific Injury or Treatment** (from_____to_____)
- ☐ **X-Ray** (check one or both): {} **Films** {} **Reports**
- ☐ **Laboratory Results**
- ☐ **Mental Health** (from_____to_____)

Signature of Patient	Date

- ☐ **Alcohol/Drug** (from_____to_____)

Signature of Patient	Date

- ☐ **HIV Test Results** (from_____to_____)

Signature of Patient	Date

- ☐ **Other** (specify): _____

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

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

By signing this release form, you are giving Medical Office/Hospital authorization to send records by email.

Date	Signature of Patient or Representative	Relationship to Patient