Comprehensive Internal Medicine

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Authorization for Release of Information

Patient Name: _____ DOB:_____/_____/_____

☐ Please Release Records to (include name & address):

_____

_____

☐ Obtain Records from (include name & address):

_____

_____

Please Release the Following Information Only:

☐ Office Notes ☐ EKG ☐ Labs

☐ Radiology Reports (CT, X-Ray, Ultrasound, Echo)

☐ Other (Specify): _____

I understand this authorization includes release of all medical records including HIV records, Psychiatric Mental Illness, Drug/Alcohol Abuse records, available diagnostic testing information, hospital records, Venereal disease and any other statutory protected diseases. When my information is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. This authorization and consent will expire ninety (90) days following the date signed. I understand that I may revoke this authorization and consent at any time except to the extent that action has previously taken in reliance hereof. My written revocation must be submitted to Comprehensive Internal Medicine Privacy Officer at the Johns Creek or Alpharetta location.

Some releases may be subject to a fee as allowed under Georgia state law O.C.G.A. 31-33-3

By signing this authorization, I authorize Comprehensive Internal Medicine to use and/or disclose certain protected health information (PHI) about me to or for the parties listed above.

_____ _____/_____/_____

Patient (or guardian) Signature Date