

MEDICAL RECORDS RELEASE FORM

PATIENT INFORMATION

Patient Name _____

Street Address _____

Phone Number _____

Today's Date _____

Month / Day / Year (xxxx) _____

City/State _____

Zip Code _____

Date of Birth

I AUTHORIZE

Name of Provider/Facility _____

Street Address _____

Phone _____ Fax _____

City/State _____

Zip Code _____

to **RELEASE** my medical records **TO/FROM** (select below) the following Southeastern Rheumatology Alliance Practices:

- Arthritis and Rheumatology of Georgia**
 980 Johnson Ferry Rd • Suite 220
 Atlanta, GA 30342
Phone: (404) 255-5956
Fax: (404) 255-3908
- Arthritis and Rheumatology of Georgia**
 1816 Eagle Dr • Suite 200B
 Woodstock, Georgia 30189
Phone: (404) 255-5956
Fax: (770) 575-3504

INFORMATION TO BE RELEASED

Select all that apply:

- ALL** Medical Records Office Visit Notes Laboratory Reports Imaging/X-Ray Reports Medication List

Other (specify): _____

PURPOSE OF RELEASE

- Continuity of Care Personal Use Legal Insurance

Other (specify): _____

DATES OF SERVICE TO BE RELEASED (IF APPLICABLE)

From: ____/____/____ To: ____/____/____

AUTHORIZATION STATEMENT

I understand that:

- I may revoke this authorization at any time by submitting a written request to the releasing provider.
- Revocation will not apply to records already released in reliance on this authorization.
- This authorization will expire one year from the date signed unless otherwise specified: _____.
- I understand that once the records are released, they may no longer be protected by HIPAA.
- I may be charged a fee for copies of records as permitted by law.

Signature of Patient or Patient's Legal Representative

Month / Day / Year

Printed Name of Patient or Legal Representative

Relationship to Patient

FOR OFFICE USE ONLY

Date Received: ____/____/____

Released By: _____

Date Released: ____/____/____

Select One: Faxed Mailed Picked Up