MEDICAL CENTRE OF CONYERS 1445 Old McDonough Hwy. Conyers, GA 30094 770-922-9222 770-504-6318 (fax)	Medical Record # Other Requested Info: Pick Up: Mail Out: Fax:

Authorization for Release of Confidential Medical Information

Patient Name: SSN:
Date of Birth: Patient Phone Number
Treatment Date(s) to be released:

This Information is to be: _____ Released to (sending out/picking up records)
_____ Obtained from (records we are receiving)
Name of Physician/Hospital: Phone:
Address: Fax:
City, State, Zip:
Reason for Release of Medical Records: _____

Portions of records needed-Check applicable sections:

___Face Sheet
___Discharge Summary
___History & Physical
___Consultations
___Operative Report
___Abstract of Records
___ Physician's Progress Notes
___Other: Specify_____
___ER record
___Therapy Records
___Radiology Imaging Reports
___EKG/Echo/Cardiology
___Lab Report
___Pathology Report

Mental Health Assessment/Psychiatric:
___Drug/Alcohol Test Results
___HIV Testing/Information

I hereby authorize Medical Centre of Conyers to disclose or obtain medical records and/or other information obtained in the course of my diagnosis and/or treatment. I hereby release Medical Centre of Conyers from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information released. I understand that I may revoke this authorization by providing written notice of my intentions. Unless withdrawn, this consent will expire 90 days from the date signed.

_____This information is to include Medical/Surgical, Psychiatric, Substance Abuse, and HIV/AIDS information.
_____I authorize that this information may be faxed to the requesting Health Care Provider.

Patient Signature: _____ Date: _____
Patient's Representative: _____ Date: _____
Authority to sign on behalf of the patient is authorized by: _____
Witnessed by: _____
(Picture ID or the patient's signatures were used to verify identity.)

Reason for release of PHI without the patient's authorization must be documented. Select the appropriate reason(s):

___Patient is in the office now.
___Patient has an appointment on _____ time: _____
___We are the Primary Care Physician.
___This is a MVA (Motor Vehicle Accident) patient that was transported to your facility.