ATLANTA RHEUMATOLOGY CONSULTANTS
3193 HOWELL MILL RD, Ste 317
ATLANTA, GA 30327
Phone: 404.603.9090 Fax: 404.603.9634

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PATIENT NAME (please print): _____ DATE OF BIRTH: _____

PATIENT ADDRESS: _____ PHONE #: _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. **I HEREBY AUTHORIZE:**

   _____ and its affiliates and agents

2. **TO RELEASE THE FOLLOWING MEDICAL INFORMATION ABOUT ME TO:**

   Name of Organization/Person: _____ Phone #: _____

   Address: _____

3. **FOR THE PURPOSE OF:**

   ☐ Treatment ☐ Legal (Attorney) ☐ At the request of individual
   ☐ Insurance ☐ Self ☐ Other:

4. **MEDICAL INFORMATION TO BE RELEASED:**

   ☐ Office Notes ☐ Laboratory Reports ☐ Complete Records
   ☐ Operative/Procedure Report ☐ Radiology Reports ☐ Other: _____

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, your copies will be mailed along with an invoice. (approx. $0.97 per page)

- I understand that the released information may include information relating to the diagnosis, treatment, and/or examination of **ALCOHOL and DRUG USE; MENTAL HEALTH; HIV and AIDS**.
- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
- I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.
- This authorization expires twelve months from the date listed below and only covers dates of service for the dates specified above.
- Potential for redisclosure: Any disclosure carries the potential for unauthorized re-disclosure. I release Atlanta Rheumatology Consultants for any legal liability that may arise from the disclosure or redisclosure of this information.

I have read and understand this authorization. I hereby authorize the release of the above requested medical information about me.

_____	_____	_____
Signature of Patient (The person about whom the information relates)	Date of Patient's Signature	Date of Birth or Social Security Number

OR, if applicable –

_____	_____	_____
Signature of Guardian or Personal Representative of Patient's Estate	Date of Guardian's/Personal Representative's Signature	Description of Authority to Act for the Individual