

## MEDICAL RECORDS RELEASE FORM

### PATIENT INFORMATION

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date of Birth  
 Street Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone Number \_\_\_\_\_

### I AUTHORIZE

Name of Provider/Facility \_\_\_\_\_  
 Street Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_

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

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Arthritis Center of North Georgia</b><br>700 South Enota Drive, NE<br>Gainesville, GA 30501<br><b>Phone:</b> (770) 531-3711<br><b>Fax:</b> (770) 531-3718 | <input type="checkbox"/> <b>Arthritis Center of North Georgia</b><br>1715 Resurgence Drive • Suite 201<br>Watkinsville, GA 30677<br><b>Phone:</b> (706) 410-9270<br><b>Fax:</b> (706) 410-9276 |
|---|--|

### 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