Eagle's Landing Family Practice, Inc.

Authorization for Release/Disclosure of Medical Information

Please **REQUEST** Medical Information **FROM**:	Please **SEND** Medical Information **TO**:
______________________	**Eagle's Landing Family Practice, Inc.**
Name of Medical Office/Hospital	Name of Medical Office/Hospital
______________________	**211 Fairview Road**
Street Address	Street Address
______________________	**Ellenwood, GA 30294**
City, State and Zip Code	City, State and Zip Code
______________________	**770-507-4554 770-507-6413**
Phone Number/Fax Number	Phone Number/Fax Number

****Please mail records if more than 15 pages****

I hereby authorize ________________________________ to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Full Name of Patient	Date of Birth	Telephone Number
Address	State	Zip Code

Duration: This authorization shall become effective immediately and shall remain in effect until __________ (enter date) or for one year from the date of signature if no date entered.

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Redisclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Specify Records to be Released/Disclosed: (check which information is to be released/disclosed)

- ☐ **General Medical Information** (from________to________)
- ☐ **Information Regarding Specific Injury or Treatment** (from________to________)
- ☐ **X-Ray** (check one or both): {} **Films** {} **Reports**
- ☐ **Laboratory Results**
- ☐ **Mental Health** (from________to________) ______________ Signature of Patient ______________ Date
- ☐ **Alcohol/Drug** (from________to________) ______________ Signature of Patient ______________ Date
- ☐ **HIV Test Results** (from________to________) ______________ Signature of Patient ______________ Date
- ☐ **Other** (specify): ____

I request that the health information released/disclosed pursuant to this authorization be used for the following purposes only: Review of Medical Records

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization.

Date	Signature of Patient or Representative	Relationship to Patient

Lishan Bekele, M.D. Mitzi Clayton, M.D.

Veronica Mills, PA-C Maya Acharya, PA-C Meghan McQuiston, PA-C