



# 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

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Phone Number/Fax Number

\_\_\_\_\_  
Phone Number/Fax Number

**1101 Nor Tec Drive**

**Conyers, GA 30013**

**678-374-7514 678-374-7517**

**\*\*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 \_\_\_\_\_)
- Alcohol/Drug** (from \_\_\_\_\_ to \_\_\_\_\_)
- HIV Test Results** (from \_\_\_\_\_ to \_\_\_\_\_)
- Other** (specify): \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

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

**Jodi Bayley, M.D.**

**Changchun Alex Wu, M.D.**

**Anne Jordan, PA-C**