Authorization for Release/Disclosure of Medical Information

Please **REQUEST** Medical Information **FROM**:	Please **SEND** Medical Information **TO**:
	Eagles Landing Family Practice Imaging Center
Name of Medical Office/Hospital	Name of Medical Office/Hospital
	1100 Hospital Drive
Street Address	Street Address
	Stockbridge, GA 30281
City, State and Zip Code	City, State and Zip Code
	678-432-6161 678-432-3677
Phone Number/Fax Number	Phone Number/Fax Number

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__________)
- ☐ **Mammogram Films/Reports** (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

Eagles Landing Family Practice, Imaging Center
1100 Hospital Drive, Stockbridge, GA 30281
Ph: 678-432-6161 F: 678-432-3677