Email Form To:
medicalrecords@elfp.com

Authorization for Release/Disclosure of Medical Information

Please **REQUEST** Medical Information **FROM**:	Please **SEND** Medical Information **TO**:
ELFP Medical Records Department	
Name of Medical Office/Hospital	Name of Patient/Facility
1502 W 3rd Street	
Street Address	Street Address
Jackson, GA 30233	
City, State and Zip Code	City, State and Zip Code
678-774-0430 678-826-5911	
Phone Number/Fax Number	Email Address/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.

(Patient) First Name	(Patient) Last Name
Date of Birth	Phone Number

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________) ____________ Patient Initial ____________ Date
- ☐ **Alcohol/Drug** (from________to________) ____________ Patient Initial ____________ Date
- ☐ **HIV Test Results** (from________to________) ____________ Patient Initial ____________ 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.

By signing this release form, you are giving Eagles Landing Family Practice authorization to send records by email.

Date	Signature of Patient or Representative	Relationship to Patient