

Authorization for Release of Medical Information

Date: _____ Patient Name: _____ Date of birth: _____
FIRST M.I. LAST

Home Phone: _____ Daytime Phone: _____

Home Address: _____
STREET CITY STATE ZIP

I authorize Premier Primary Care Medicine to:

obtain information from:

release information to:

Name of provider/facility: _____ Phone: _____

Address: _____
STREET CITY STATE ZIP

Fax number: _____

Specific description of information to be released:

Complete Medical Records Progress Notes Labs Reports Radiology/Xray Reports

I authorize the release of records that may include diagnosis and treatment of HIV, alcohol & drug usage and/or mental health records). I understand that I may cancel this authorization at any time by submitting a written request to Premier Primary Care Medicine except where a disclosure has already been made in reliance on my prior authorization. If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed.

SIGNATURE OF PATIENT OR GUARDIAN

DATE

RELATIONSHIP TO PATIENT (IF NOT PATIENT)

Releasing provider or facility: Please return this form to

**Premier Primary Care Medicine
3903 S. Cobb Dr., Suite 200 • Smyrna, GA 30080**

or fax to (770) 437-6911