PIEDMONT INTERNAL MEDICINE

Piedmont Internal Medicine
Authorization to Release Medical Records

Patient Name_____ MRN/SSN_____

Date of Birth_____ Phone # (best reached) _____

I, _____ authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient.

Information Needed For:

_____ Continuing Medical Care
_____ Insurance
_____ Legal Purpose
_____ Other: (please specify) _____

_____ Personal
_____ School
_____ Disability/SSA/FMLA

Information to be Released or Accessed:

_____ History and Physical
_____ Operative Report
_____ Lab/Pathology Report
_____ ER Record
_____ Other: (please specify) _____

_____ Consultation Report
_____ Discharge Summary
_____ Radiology Report
_____ Face Sheet

The above information may be released to:

Piedmont Internal Medicine/Dr. _____ Phone: 404-351-7467, Fax:
Address: 105 Collier Road NW Suite 5020/5040, Atlanta, GA 30309

Requesting Records:

FROM: _____ Phone: _____
Address: _____ Fax: _____
_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but it is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. The authorization will expire in six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

DATE: _____

Signature: _____
(Patient/Legally Authorized Representative)

_____
(Printed Name of Patient or Legally Authorized Representative)