AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
Ivy Falls Family Medicine

Date: _____/_____/_____

Patient Name: _____ Date of Birth: ____/___/___

Social Security Number: _____

Patient Address: _____
(Street) (City) (ST) (Zip)

Release Records To: **Release Records From:**

Ivy Falls Family Medicine_____ _____

10475 Medlock Bridge Rd, Ste 815_ _____

Duluth GA 30097_____ _____

Fax 678-990-4824_____ May records be faxed? □Y □N

Please send a copy of my medical records as indicated below:
All records _____ Lab Reports _____ H&P _____ X-ray Reports _____
Operative Records _____ Prenatal Records _____ Emergency Room _____
Other _____

Purpose for releasing medical information _____

_____ _____
Signature of Patient, Parent or Legal Guardian **Witness**

_____
Date

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

_____ _____
Signature of Patient **Witness**

_____
Date