PMS ID

WEST
GEORGIA
DERMATOLOGY

Authorization for Use or Disclosure of Protected Health Information

Patient Information:

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Date(s) of Service: _____

Release Information To:

☐ *I hereby authorize West Georgia Dermatology to release my medical record information to:*

Name/Facility: _____ Attn: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Delivery Preference (check one):

☐ Mail copies to address above ☐ Hold for patient pickup

☐ Secure email: _____ ☐ Fax: _____

☐ Discuss Medical Information with: _____

Information To Be Released (check all that apply):

☐ Progress Notes ☐ Laboratory Notes

☐ Pathology Reports ☐ All Records

☐ Other (specify records needed): _____

Purpose of Request or Disclosure (check one): *Please list the the reason or purpose for the release:*

☐ Continued Patient Care ☐ Insurance Claim/Application

☐ Attorney/Legal ☐ Change of Physician/Relocation

☐ Other: _____ ☐ Personal Use

I understand that the information released is for the specific purpose stated above. I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I will not hold any employee of West Georgia Dermatology liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has already been taken. This consent will expire 90 days after the date of my signature.

_____ _____ _____

Signature of Patient | Relationship to Patient (self, parent, spouse) | Date

Please fax completed form to (770) 838-7755 or mail to 109 Professional Pl, Carrollton, GA 30117, Attn: Medical Records. If you have any questions regarding this request, please call (770) 838-9333.

For office use only. Date Received: _____ Date Processed: _____ Staff initials: _____