

W *falany & hulse* WOMEN'S CENTER

Authorization For Release of Confidential Medical Information

Patient Name: _____ SSN: _____

Date of Birth: _____ Patient Phone Number: _____

Treatment dates to be released: All Records

This information is to be released from:

Healthcare Provider: _____ Phone number: _____

Address: _____ Fax number: _____

City, State, Zip: _____

Purpose of Disclosure (check one):

Insurance/Billing Legal Continuing Care

Other Specify _____

Please Remit Medical Records to: 10515 Bells Ferry Rd., Bldg. B, Ste. 200 36 Mulberry Street, Suite 6,
Canton, Georgia 30114 East Ellijay, Georgia 30540
Ph: 770-720-8551 Fax: 770-345-2738 Ph: 706-698-6400 Fax: 706-698-6401

Portions of Record needed (check all that apply):

All Records Most Recent Visit Mammogram / Radiology Report Labs / Pathology

Other Records Specify: _____

I hereby authorize you, your physicians, and your employees from any liability arising from the release of the medical information specified above. I understand that I may revoke this authorization by providing written notice of my intentions.

I understand that unless withdrawn, this consent will expire 120 days from the date signed.

This information may include Medical / Surgical, Psychiatric, Substance Abuse, and HIV / AIDS information.

Patient's Signature

Date

Patient's Representative

Date

Authority to sign on behalf of the patient is authorized by: _____

Witnessed by: _____

Picture ID or the patient's signatures were used to verify identity

Patient has an appointment scheduled for: _____

PROHIBITION OF RE-DISCLOSURE:

This information is disclosed from confidential records by law. Any further disclosure is strictly prohibited.

*10515 Bells Ferry Road, Building B, Suite 200 Canton, Georgia 30114 ~ 770-720-8551
36 Mulberry Street, Suite 6, East Ellijay, Georgia 30540 ~ 706-698-6400*