North Atlanta Women's Care

6300 Hospital Pkwy, Ste 375
Johns Creek, GA 30097

4040 Old Milton Pkwy, Ste 200
Alpharetta, GA 30005

Phone: 770.771.5270 Fax: 770.771.5279

Authorization for Release of Medical Information

Patient's Name _____ Date of Birth _____/_____/_____

Address _____

City/State/Zip Code _____

SS# _____ Patient's Phone # _____

FOR OFFICE USE ONLY

Date of Request _____/_____/_____ **Date Needed** _____/_____/____

☐ I authorize North Atlanta Women's Care to **release** information to:	☐ I authorize North Atlanta Women's Care to **obtain** information from:
_____ Name of Provider or Facility	_____ Name of Provider or Facility
_____ Address	_____ Address
_____ City/State/Zip Code	_____ City/State/Zip Code
Phone # _____ Fax # _____	Phone # _____ Fax # _____

Purpose for the Request: (Check one) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Transfer of Care ☐ Other

Type of Record Requested: (Check one)

☐ Immunization History ☐ Administered by the Clinic Only ☐ Include Records Submitted to the Clinic ☐ All Medical Records

Related to a Specific Illness or Injury_____
Specify Illness / Injury Date(s) of Treatment

☐ Treatment Summary (includes history / physical, laboratory test & x-ray reports, operative reports, pathology)

☐ Specific Information (Select one or more, as applicable)

☐ Procedure Report ☐ History & Physical ☐ Physical Therapy ☐ Laboratory Test Results

☐ X-ray Reports ☐ Other _____
(Please Describe)

☐ Entire Copy of the Record Checked Above

Authorization Valid For: (Check one)

☐ This Request Only

☐ One Year from the Date of this Authorization.

☐ This Request **and** for Medical Records of any **Future** treatment of the Type Described Above Until _____(insert date).

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, 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 redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical Records are faxed in Cases of Medical Necessity Only.

Signature of Patient or Representative _____Date _____/_____/_____

Relationship to Patient *(if requester is not the patient)*