Urology of Greater Atlanta, LLC
290 Country Club Drive Suite 100
Stockbridge, GA 30281
Phone (770) 474-5281 Fax (770) 389-8674

Patient's Name ______________________________

Patient's Address ______________________________

Date of Birth ____________________ **Phone** ______________________________

I do hereby authorize Urology of Greater Atlanta, LLC to:

Release of all medical records pertaining to me:

(*WITH THE EXCEPTION OF ALCOHOL & DRUG*

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ABUSE AND OR HIV/AIDS RELATED INFORMATION)

Obtain all medical records pertaining to me from:

Name:

Address: ______________________________

Phone: ______________________________

Fax: ______________________________

For the purpose of:

Moving away   Personal copy   Transfer to new physician

Second opinion   Another treating physician   ______________________________

The records should be:

______ Sent to me at my home address on file

______ Sent to Urology of Greater Atlanta, LLC

______ Sent to the following person (s)

Name: ______________________________

Address: ______________________________

City State Zip: ______________________________

Phone: ______________________________

Facsimile: ______________________________

This Authorization shall remain in effect until revoked by me in writing. If not revoked by me in writing, the Authorization shall remain in effect for one (1) year from the date of the signature below. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this Authorization Form. I understand that if I wish to revoke this Authorization, I must do so in writing and present my written revocation to Urology of Greater Atlanta, LLC. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this Authorization. I need not sign this Authorization in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules.

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Patient Name   **Date of Birth**   **Social Security Number**

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Signature   **Date**   **Relationship to Patient**

When a representative of the patient signs this form, the representative must provide a description of such representative's authority to act for the patient: ______________________________.

Staff initials: ____________________