Athena Medical Clinic and Sleep Medicine Associates

1500 Oglethorpe Ave. Suite 3100. Athens, GA 30606
Phone 706-850-6383 Fax 706-850-6389

Release of Medical ~~Information Consent~~

Patient's Name _____ dob _____
Street Address _____
City, State, Zip _____, _____, _____
Patient's SSN _____ - _____ - _____ Phone # _____

☐ I authorize Athena Medical Clinic and Sleep Medicine Associates to release information to:
Provider or Facility _____
Address _____
City, State, Zip _____
Phone _____ Fax _____

☐ I authorize Athena Medical Clinic and Sleep Medicine Associates to obtain information from:
Provider or Facility _____
Address _____
City, State, Zip _____
Phone _____ Fax _____

Purpose for this request ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other

Type of Records Requested ☐ All medical records ☐ Other _____
☐ Specific Illness/Injury ☐ Treatment Dates _____

Authorization Valid (check one) ☐ This request only ☐ Effective until _____ (date)
☐ One year from the date of this authorization

I understand:
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 healthcare provider, except when 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.

_____ _____
Patient's Signature Date

_____
Relationship (if requester is not the patient)