Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me. Please release a copy of my medical records or a summary or narrative of my protected health information to the person(s) or entity listed below.

Patient Name: _____

Social Security Number:_____ DOB: _____

MEDICAL RECORDS RELEASED FROM:

Physician's name/Clinic _____

Address _____City, State, Zip_____

Phone _____ Fax_____

MEDICAL RECORDS SHOULD BE SENT TO:

Prestige Healthcare Atlanta, LLC

3886 Princeton Lakes Way, Suite 280, Atlanta, GA 30331

404-346-7100 Fax 404-346-1122

INFORMATION TO BE DISCLOSED:

___Complete Medical Records (Including HIV, STD Screening)

___Specific Labs dated _____ to _____ Specify Labs _____

___Date of Medical Records from _____ to _____

___Other, please specify _____

REASON FOR REQUEST:

__Out of town move __Change in Insurance ___ Insurance claim ___Legal ____Consult/2nd Opinion ___Personal Copy

__Transfer of care __Other

REVOCATION:

I understand that this authorization will be in effect for SIX (6) months unless cancelled by me in writing.

Patient Signature (or parent guardian or legal representative)_____

A FEE FOR THE PROCESSING OF MEDICAL RECORDS MAY APPLY