ALPHA FAMILY MEDICINE INC.

Enhancing Life & Excelling in Care

480 Main Street, Suite 202, Alpharetta, GA 30009
Tel: 678-619-1974 ❖ Fax: 678-619-1975
www.alphafammed.com

DISCLOSURE OF PROTECTED HEALTH INFORMATION
AUTHORIZATION TO RELEASE MEDICAL RECORDS

_____ _____
Patient's Name Date of Birth

_____
Address

_____ _____
Phone Number Last 4 digits of SS#

I authorize Alpha Family Medicine to *RELEASE* my medical records to the following:

☐ Self ☐ Guardian/Next of Kin/Power of Attorney ☐ Another Medical Facility
☐ Insurance ☐ Other _____

Name _____
Address _____
Phone # _____ Fax # _____
Reason for disclosure _____

Type of information to be disclosed (Provide requested dates if known):
*****PLEASE NOTE, WE CAN ONLY RELEASE OUR RECORDS, WE CANNOT RELEASE OTHER PHYSICIAN'S RECORDS THAT HAVE BEEN SENT TO US*****

☐ Entire Medical File (Includes all patient information as listed)
☐ Imaging results (specify type/date)_____
☐ Immunizations ☐ Most recent records (6 months) ☐ Most Recent Labs
☐ Visit Summaries only (specify date range) _____

IMPORTANT: Your Medical File may contain AIDS/HIV history, substance abuse, drug & alcohol history.