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 RECEIVE MEDICAL RECORDS

Patient ____ DOB ____

Street Address __________________________________ City ______________ Zip code __________________

Phone #____

I authorize the release of my medical records from the following:

Name/Physician /Hospital or Facility: ____

Address: ____

Phone #: ______________________________________ Fax #: ______________________________________

Reason for release: ____

Medical Records can be sent via mail or faxed to:

ALPHA FAMILY MEDICINE
480 N. Main Street, Suite 202 Alpharetta, GA 30009
Fax number: (678) 619-1974

Type of information to be disclosed (Provide requested dates if known):

☐ Entire Medical File (Includes all patient information as listed) ☐ Most recent records (Last 3 months)

☐ Immunizations/ Genetic Testing (specify date) ______________ ☐ Most Recent Labs ☐ AIDS/HIV, if any

☐ Imaging results (specify type/date) ______________________ ☐ Substance and Drug Abuse, if any

☐ Psychological or Psychiatric conditions, if any

I understand this authorization will expire one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company(s). I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by federal confidentiality rules. I accept full responsibility for any copying or shipping fees and any applicable sales tax that may be charged by law.

____ ________________________________

Patient or Patient Representative (PRINT) Today's Date

____ ________________________________

Patient or Patient Representative (Signature) Relationship to Patient