Family Practice Dept
15 RiverbendDrive, Suite 100
Rome, GA 30161
Phone: (706)291-0884
Fax: (706)291-1241

Authorization to Release Medical Records

Patient Name:_____ Date of Birth:_____
Patient SS#:_____ Patient Phone Number:_____

I authorize Northwest Georgia Medical Clinic to (choose one):
ALL INFORMATION MUST BE COMPLETED

☐ RECEIVE RECORDS FROM:_____
Address:_____
_____
Phone Number:_____ Fax Number:_____
☐ RELEASE RECORDS TO:_____
Address:_____
_____
Phone Number:_____ Fax Number:_____
Information Requested:
☐ Most recent information ☐ Other (Specify)_____
☐ Entire chart _____
Are you leaving the practice?_____ If yes, reason:_____
Do you have an upcoming appointment?_____ When:_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this release with the EXCEPTION of:

Initials
_____Substance abuse, if any
_____Psychological or psychiatric conditions, if any

Initials
_____AIDS/HIV, if any

Other (please specify)_____
The purpose of this request is: "at the request of the individual."

The covered entity may not condition treatment or payment on whether or not the individual signs an authorization. There is the potential that the disclosure of your health information to a non-covered entity pursuant to this authorization may be subject to redisclosure and no longer protected. Expiration or revocation of authorization - I understand that I may revoke this authorization at any time and that unless an earlier date is specified, it will automatically expire 12 months after the date affixed below. Use of copies - A copy of this authorization may be utilized with the same effectiveness as an original. **Note this may take up to 7-10 days to process after receiving the form.**

_____ _____
Patient Name (print) Person authorized to sign for patient/Relationship to patient

_____ _____
Patient Signature Signature

Date:_____ Date:_____