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Prestige Healthcare Atlanta, LLC
Where Wellness is Our Focus

MEDICAL 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:

Physician's Name/Clinic: _____
Address: _____ City, State, Zip: _____
Phone: _____ Fax: _____

INFORMATION TO BE DISCLOSED:

_____Complete Medical Records (Including HIV, STD Screening)
_____Specific Labs Dated_____Specify Lab_____
_____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 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): _____ Date: _____

A FEE FOR THE PROCESSING OF MEDICAL RECORDS MAY APPLY