THE FAMILY MEDICINE CLINIC

12 MEDICAL DR. /PO BOX 200185

CARTERSVILLE, GA 30120

PHONE 770-386-1000 / FAX 770-386-9165

RELEASE OF INFORMATION

DATE_____ NAME_____

DOB_____ SOCIAL SECURITY NUMBER_____

ARE YOU TRANSFERRING TO ANOTHER PRIMARY CARE PHYSICIAN?_____

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS INCLUDING AIDS/HIV LAB RESULTS, PSYCHIATRIC EVALUATIONS, AND TREATMENT OF ANY FORM OF ABUSE OR ADDICTION BY MAIL OR FAX.

I UNDERSTAND THAT THIS RELEASE WILL BE VALID FOR 90 DAYS FROM THE DATE SIGNED UNLESS I REVOKE THIS REQUEST IN WRITING.

I UNDERSTAND THAT A COPY OR FAX OF THIS REQUEST IS VALID IN LIEU OF THE ORIGINAL.

RELEASE INFORMATION FROM:_____

_____

PHONE_____FAX_____

SEND INFORMATION TO: _____

_____

PHONE_____FAX_____

ALL RECORDS?_____ SPECIFIC RECORDS_____

PATIENT SIGNATURE_____DATE_____

WITNESS SIGNATURE_____DATE_____