AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Quail Ridge Family Practice, LLC
1 Doctors Park - Cairo, GA 39828
Phone (229) 378-8110 FAX (229) 378-8109

Patient: ____ **Date of Birth**: _____/_____/_____
Address: ____
City/State/Zip: ____
Telephone: ____

I authorize the release of medical information as indicated below:

FROM: Practice/Name - ____
Address - ____
Phone/Fax - ____

TO: Practice/Name - ____
Address - ____
Phone/Fax - ____

Information to be disclosed:

- ☐ All Medical Records
- ☐ X-ray Reports
- ☐ Lab/Pathology Reports
- ☐ Immunization Records
- ☐ Outpatient Notes
- ☐ Other –

Reason for disclosure:

- ☐ Transferring records/discontinuing care
- ☐ Continuity of care
- ☐ Attorney/Legal
- ☐ Disability determination
- ☐ Worker's compensation
- ☐ Personal use
- ☐ Insurance
- ☐ Other -

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS and/or HIV. It may also include information regarding alcohol or drug abuse, mental health or psychiatric disorders, and/or genetic information (including genetic test results).

☐ **I authorize release of this information**. **Initial and Date:** ______________________

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this authorization will remain in effect for 90 days after the authorization is signed and dated. I also understand that I may revoke this authorization at any time by notifying in writing Quail Ridge Family Practice, to whom this authorization was originally addressed, but if I do, it will not have any affect on actions that Quail Ridge Family Practice took before it received the revocation. I understand that upon expiration of the authorization, no further use or disclosure of the information will be made.

I have read and understand this information. I am the patient or am authorized to act on behalf of the patient to sign this document verifying authorization for the use or disclosure of the protected health information under the above stated terms.

____ ______________________
Signature of patient **Date**

____
Signature of legal representative and relationship to patient **Date**

____
Signature of Witness **Date**

If signed by legal representative, indicate authority to act for individual:

☐ **Parent** ☐ **Guardian** ☐ **Executor of Estate** ☐ **Health Care Power of Attorney** ☐ **Other** _______________