

Authorization and Consent for Release of Information

I, _____, authorize and request _____

to release to _____
Name of Physician

Address

a complete copy of the medical records of _____
Patient

from _____ to _____
Date Date

Reason for release: _____

I am aware that some of the information in the requested medical records may be of a sensitive nature. By signing this Release, I am granting permission for information pertaining to the below-mentioned areas to be released. I waive any privilege or confidentiality existing under federal or state law regarding such information, including, but not limited to, protection afforded to:

- (1) Communications made to a psychiatrist (O.C.G.A. §24-9-21)
- (2) Communications made to a licensed applied psychologist (O.C.G.A. § 43-36-16)
- (3) Medical information concerning drug dependency (O.C.G.A. §26-8-17)
- (4) Medical information concerning alcohol and drug dependency (O.C.G.A. §37-1-166)
- (5) Medical information regarding mental illness (O.C.G.A. §37-3-166)
- (6) Medical information concerning mental retardation (O.C.G.A. §37-4-125)
- (7) Medical information concerning alcohol and drug abuse (42 C.F.R. Part 2)
- (8) AIDS confidential information (O.C.G.A. §31-22-9.1 and §24-9-47)

This Authorization and Consent is in effect for ninety (90) days. Our office will act on this Release within the first week of receipt. The Authorization and Consent will terminate ninety (90) days from the date appearing below.

Date: _____ Patient's Account #: _____

Patient's Birthdate: _____ Signature: _____
(Patient or Authorized Person)

Witness: _____

NOTE TO RECIPIENT:

The information that has been disclosed to you is or may be protected by state and federal law. You are prohibited from making any further disclosure of this information unless further authorization is obtained or disclosure is otherwise permitted by law. A general authorization for release of information may not be sufficient.

The information requested was released to _____

on _____ by _____