

MERINDA HERRON, M.D. 669-B PIEDMONT AVENUE ATLANTA, GA 30308

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Patient Home Address _____ City _____ State _____ ZIP _____

I do hereby authorize Dr. Merinda Herron to release any information contained in the above patient's medical record including, but not limited to, psychiatric or psychological information, infectious or contagious disease information, including HIV/AIDS confidential information, and information about drug and alcohol abuse or treatment.

Please mail the requested information to the following address:

Name: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

There is a fee of \$18.00 plus \$.50 per page for a copy of each record. Payment must be by cash, money order or certified check. The estimated fee and a signed copy of this release must be received before the request can be processed. Please mail the estimated fee to Dr. Herron at the above address.

Estimated fee for the record information requested: \$ _____

Patient Signature _____ Date _____

Guardian's Signature _____ Date _____

Georgia law gives you the right to receive a copy of all information contained in your medical record. The law also states that the owner of the medical record, Dr. Merinda Herron, has the right to charge a reasonable fee for the costs of making and transmitting copies of that information. Georgia law, OCGA Section 31-33-3 says that reasonable amount is \$20.00 plus postage plus \$.75 per page for the first 20 pages copied, \$.65 per page for pages 21 through 100 and \$.50 for pages in excess of 100.