EMORY CLINIC

# AUTHORIZATION FOR RELEASE OF INFORMATION TO THE EMORY CLINIC, INC.

***To be completed if records are being requested, from another facility, to be sent to The Emory Clinic, Inc.***

_____ __XXX__-__XX__-_____ _____/_____/_____

Patient's Name (PLEASE PRINT) Last Four of Patient's SS# Date of Birth

_____ (_____)_____-_____ (_____)_____-_____

Address Street City/State Zip Home Phone Work Phone

## PERSON OR FACILITY FROM WHICH INFORMATION IS BEING REQUESTED

_____

Name of Facility (PLEASE PRINT)

_____

Address Street City/State Zip

( ) - ( ) -

Telephone Fax

I hereby authorize the facility named above to release information contained in the above-named patient's medical records, including records, if any, for treatment of physical and/or mental illness, treatment of chemical dependency and/or alcohol abuse, or testing or treatment of any communicable or infectious disease, such as Acquired Immunodeficiency Syndrome (AIDS); Human Immunodeficiency Virus (HIV); Acquired Immunodeficiency Syndrome Related Complex (ARC); Venereal Disease or Hepatitis to:

**Dr.**
Emory Family Medicine at Dunwoody
4500 N. Shallowford Road
Dunwoody, GA 30338
**Phone: 404-778-6920 Fax: 404-778-6901**

**1)** Please provide the medical record information checked below (include physician dates of service if known):

| INFORMATION: | DATES: | INFORMATION: | DATES: |
|---|---|---|---|
| [ ] Office Notes | _____ | [ ] EKG Reports | _____ |
| [ ] Discharge Summary | _____ | [ ] X-Ray Reports | _____ |
| [ ] History & Physical | _____ | [ ] Other | _____ |
| [ ] Operative Reports | _____ | | |
| [ ] Pathology Reports | _____ | | |
| [ ] Laboratory Reports | _____ | | |

**2)** Purpose or need for disclosure:_____

**3)** I authorize the facility named above to send the medical information requested by fax.

***Note:*** This authorization will expire sixty (60) days from the date signed unless otherwise specified below:

_____ _____

Witness Signature of patient, parent of minor, legal guardian or estate representative

_____ _____

Date Date

## PLEASE COMPLETE AND SEND TO HEALTH CARE FACILITY