Atlanta Plastic & Reconstructive Specialists, LLC

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Authorization for Release of Medical Records

Date of Request: _____

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Phone Number: _____

☐ Fax ☐ Mail ☐ Pickup

Purpose or need for information: _____

_____

- ☐ All Records
- ☐ Labs/Pathology Reports
- ☐ Progress Notes
- ☐ Billing Statements
- ☐ Implant Information (including operative report)
- ☐ Other _____

I hereby authorize Atlanta Plastic & Reconstructive Specialists, LLC

RELEASE/OBTAIN
(circle one)
The protected health information regarding the above named person to/from:

Person/Institution: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I understand that providing my authorization is voluntary. I understand that I may revoke this authorization, in writing, at any time except to the extent that disclosure was made prior to the time I revoked this authorization. I further understand that I may inspect and receive copies of the information to be disclosed.

I understand that the health records and information disclosed, or some portion thereof, may be protected by the Federal Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that it is possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPAA. I further understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations.

Release of the following information may be governed by additional laws. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information.

HIV/AIDS ____ Mental health information ____ Genetic testing information ____ Drug/alcohol, treatment, or referral info. ____

This Authorization for Release of Protected Health Information shall expire one (1) year from the date below. **My signature below acknowledges that I have read, understand, and authorize the release of the information.**

Signed: _____ **Witness:** _____
(Patient/Legal Guardian)