LiveOn Medical Center

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name _____ Social Security No._____

Address _____ Date of Birth _____

City, State, Zip _____

Home/Cell Phone _____ Work Phone _____

I authorize the LiveOn Medical Center to disclose the health information as directed below by fax or by mail to the address specified below.

Provider Name: _____ Phone Number: _____

RECORDS AUTHORIZED TO BE RELEASED:

- ☐ Office Notes (complete medical record)
- ☐ Outpatient records
- ☐ Psychiatric and other mental health records
- ☐ Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)
- ☐ Lab reports
- ☐ Radiological images (x-rays)
- ☐ Consultation notes or reports
- ☐ HIV and/or AIDS related information
- ☐ Other_____

_____

PLEASE SEND MY HEALTH RECORDS TO (Please Print Clearly):

_____

_____

_____

_____

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the healthcare provider, but that revoking this authorization will not affect disclosures made or actions taken before revocation is received.

I also understand that:

- I am not required to sign this authorization and that my healthcare or payment for care will not be affected by my refusal.
- Federal privacy regulations will no longer apply to the information disclosed, and that may re-disclose the information.
- A copy of this authorization may be utilized with the same effectiveness as an original.

_____

PATIENT OR REPRESENTATIVE (PLEASE SIGN) DATE

_____

NAME OF REPRESENTATIVE (PLEASE PRINT) RELATIONSHIP TO PATIENT

LiveOn Medical Center ♦ 80 Vinings Drive, McDonough, GA 30253 ♦phone (770) 302-6780 ♦ fax (678) 782-3776