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 named healthcare provider to disclose the health information as directed below in person or by mail to the address specified at the time of the request.

Provider Name: _____________________________ Phone Number: __________________________

RECORDS AUTHORIZED TO BE RELEASED: ***LAST 2 YEARS ONLY***

- ☐ 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: ***IF MORE THAN 30 PAGES – PLEASE MAIL***

LiveOn Medical Center
80 Vinings Drive
McDonough, GA 30253

Phone: (770) 302-6780
Fax: (678) 782-3776

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 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