MODERN FAMILY MEDICINE
3460 Summit Ridge Parkway, Suite 304, Duluth, GA 30096
Phone: 770.771-5115 Fax: 770.771.5116

Authorization for Release of Medical Information

Patient's Name _____ Date of Birth _____/_____/_____

Address _____

City/State/Zip Code _____

SS# Patient's Phone #

FOR OFFICE USE ONLY

☐ I authorize Modern Family Medicine to **release** information to:

_____
Name of Provider or Facility

_____
Address

_____
City/State/Zip Code

Phone # _____
Fax # _____

☐ I authorize Modern Family Medicine **obtain** information from:

_____
Name of Provider or Facility

_____
Address

_____
City/State/Zip Code

Phone # _____
Fax # _____

Date of Request _____/_____/_____ **Date Needed** _____/_____/____

Purpose for the Request: (Check one) ☐ Healthcare ☐ Personal ☐ Transfer of Care ☐ Other

Type of Record Requested: (Check one)

☐ Immunization History ☐ Include Records Submitted to the Clinic ☐ All Medical Records Related to a Specific Illness or Injury_____
Specify Illness / Injury Date(s) of Treatment

☐ Treatment Summary (includes history / physical, laboratory test & x-ray reports, operative reports, pathology)

☐ Specific Information (Select one or more, as applicable)

☐ Procedure Report ☐ History & Physical ☐ Physical Therapy ☐ Laboratory Test Results

☐ X-ray Reports ☐ Other _____
(Please Describe)

☐ Entire Copy of the Record Checked Above

Authorization Valid For: (Check one)

☐ This Request Only

☐ One Year from the Date of this Authorization.

☐ This Request **and** for Medical Records of any **Future** treatment of the Type Described Above Until _____(insert date).

I understand that:

My right to healthcare treatment is not conditioned on this authorization.
I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
There is a charge for the requested records. We do require 2 weeks turn around once the fee has been paid.

NOTE: Medical Records are Faxed in Cases of Medical Necessity Only.

Signature of Patient or Representative _____Date _____/_____/_____

Relationship to Patient (*if requester is not the patient*) _____