

**Authorization for Release of Medical Information
Laureate Medical Group, P.C.**

550 Peachtree Street, NE
Suite 1550
Atlanta, GA 30308
Phone: 404-892-2131
Fax: 404-215-9222

5673 Peachtree Dunwoody Rd.
Ste. 775
Atlanta, GA 30342
Phone: 404-256-8500
Fax: 678-539-3181

7823 Spivey Station Blvd.
Ste. 310
Jonesboro, GA 30236
Phone: 770-996-1122
Fax: 770-907-1429

3400-C Old Milton Pkwy.
Ste. 500
Alpharetta, GA 30005
Phone: 678-775-2284
Fax: 678-775-2285

Patient Name	Date of Birth	Social Security #
Address		Telephone #

I hereby authorize _____

_____ release information to _____ obtain information from

Name of Person / Organization

Address of Person / Organization

For the following purpose _____

For treatment dates _____

Select Portions

- | | |
|--|--|
| <input type="checkbox"/> Laureate Medical Group Office Notes
<input type="checkbox"/> Laboratory Reports
<input type="checkbox"/> X-Ray Reports
<input type="checkbox"/> ECHO Reports
<input type="checkbox"/> Stress Test Reports | <input type="checkbox"/> EKG
<input type="checkbox"/> Phone Messages
<input type="checkbox"/> Entire Laureate Medical Group Record
<input type="checkbox"/> Holter Report
<input type="checkbox"/> Other _____ |
|--|--|

<input type="checkbox"/> I have a request for limitations and restrictions of PHI on file

<input type="checkbox"/> I acknowledge and hereby consent to such, that the released information may contain alcohol/drug abuse, (Initials) psychiatric, HIV testing, HIV results, or AIDS information.
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This authorization expires 90 days from the date signed below and covers only treatment for the dates specified above.
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I, the undersigned, have read the above and authorize the staff of Laureate Medical Group to disclose such information herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that redisclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This office is released and discharged of any liability and the undersigned will hold this office harmless, for complying with this Authorization for Release of Medical Information”.

Date

Signature of Patient/Parent/Conservator/ Guardian

Relationship to Patient

