

**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: 404-256-8506

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

<b>Patient Name</b>	<b>Date of Birth</b>	<b>Social Security #</b>
<b>Address</b>		<b>Telephone #</b>

I hereby authorize \_\_\_\_\_

\_\_\_\_\_ release information to \_\_\_\_\_ obtain information from

\_\_\_\_\_  
Name of Person / Organization

\_\_\_\_\_  
Address of Person / Organization

For the following purpose \_\_\_\_\_

For treatment dates \_\_\_\_\_

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

_____ I have a request for limitations and restrictions of PHI on file
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_____ I acknowledge and hereby consent to such, that the released information <b>may</b> 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 I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it.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