

**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 Peach tree Dunwoody Rd
Ste. 775
Atlanta, GA 30342
Phone: 404-256-8500
Fax: 404-256-8506

29 SW Upper Riverdale Road
Ste. 210
Riverdale, GA 30274
Phone: 770-996-1122
Fax: 770-907-1429

3400C 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 : LAUREATE MEDICAL GROUP

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

I have a request for limitations and restrictions of PHI on file

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.

This authorization expires 90 days from the date signed below and covers only treatment for the dates specified above.

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 I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it.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