*Midtown*
550 Peachtree Street, NE,
Suite 1550
Atlanta, Georgia 30308
Telephone (404) 892-2131
Facsimile (404) 215-9222

LAUREATE MEDICAL GROUP
*Medical Excellence. Compassionate Care.*
AN AFFILIATE OF NORTHSIDE HOSPITAL

*Sandy Springs*
6135 Barfield Road,
Suite 200
Atlanta, Georgia 30328
Telephone (404) 256-8500
Facsimile (404) 256-8506

*Alpharetta*
3400-C Old Milton Parkway,
Suite 500
Alpharetta, Georgia 30005
Telephone (678) 775-2284
Facsimile (678) 775-2285

*Jonesboro*
7823 Spivey Station Boulevard,
Suite 310
Jonesboro, Georgia 30236
Telephone (770) 996-1122
Facsimile (770) 907-1429

*East Cobb*
1121 Johnson Ferry Road, Building 1,
Suite 320
Marietta, Georgia 30068
Telephone (678) 718-2940
Facsimile (678) 718-2941

*Holly Springs*
684 Sixes Road,
Suite 265
Holly Springs, Georgia 30115
Telephone (770) 720-2221
Facsimile (770) 720-2282

# Authorization for Release of Medical Information

| **Patient Name** | **Date of Birth** | **Last 4 of SS #** |
|---|---|---|
| **Address** | | **Telephone #** |

I hereby authorize **LAUREATE MEDICAL GROUP AT NORTHSIDE, LLC**

☐ to release information to ☐ to obtain information from

_____
Name of Person / Organization

_____
Address of Person / Organization

For the following purpose _____

For treatment dates _____

**Select Portions**

☐ Entire Laureate Medical Group Record
☐ Laureate Medical Group Office Notes
☐ Laboratory Reports
☐ X-Ray Reports
☐ Holter Report
☐ ECHO Reports
☐ EKG
☐ Phone Messages
☐ Stress Test Reports
☐ 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, psychiatric, HIV testing, HIV results, or AIDS information. (Initials)

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 I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it.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