Physicians Pointe
Authorization to Release Healthcare Information

_____ _____
(PRINT PATIENT'S Full Name) (PATIENT'S Date of Birth)

_____ _____
(PRINT name of Parent/Legal Guradian, if under 18) (PATIENT'S Social Security Number)

I request to authorize the following release of my healthcare information:

☐ To ☐ From ☐ To ☐ From

_____
(PRINT Name of Physician/Facility/Agency)

Physicians Pointe
1925 Old Peachtree Road
Lawrenceville, GA 30043
Phone 770-339-5999, Fax 770-277-9159

_____
(PRINT Address)

_____
(PRINT City, State, and Zip Code)

_____
(Office Phone and Fax Number with Area Code)

*I place no limitations on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders.
*I authorize the inspection of the above information by the above named agency/person and/or to the furnishing of copies.
*I understand that I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of this authorization does not affect any health information disclosed prior to receipt of said notification.
*I hereby release Physicians Pointe and its employees from any and all liabilities, responsibilities, damages, losses, and claims which might arise from the release of the information authorized above.
*In furtherance of this authorization, I do hereby waive all provisions of the law and privileges related to the disclosures hereby authorized.
*I hereby acknowledge that I have read (or had someone read to me) the above statements, and that I fully understand the above statements, and do expressly and voluntarily authorize the disclosure of this medical information to the individual or agency named above.

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

_____.

☐ All Healthcare Information

☐ Other: _____.

The purpose for which this release is being requested is: ☐ Continuing Medical Care ☐ Legal Action/Review
☐ Insurance Reimbursement ☐ Other (Specify)_____

This authorization will expre in 6 months (12 months for school requests), unless otherwise noted here _____. No further use/disclosures as described above may be made after expiration.

_____ _____ _____ _____
(Patient or Authorized Signature) (Date) (Witness Signature) (Date)

Internal Use Only

_____ Faxed _____ Mailed _____ Picked Up/Called: _____ Date: _____ Initials: _____