



Return to:

North Georgia Pain Clinic
1320 Oakside Drive, Suite 203
Canton, GA 30114

770.479.2322 (phone)
770.720.7695 (fax)

Format Requested: ___ Print ___ CD (over 30 pages)
Paid on site by: ___ Cash ___ Card ___ Check
___ Send Invoice

Completed by: _____

Authorization for Release of Confidential Medical Information
Medical services provided by North Georgia Pain Clinic are not condition upon this authorization

Patient Name _____
Date of Birth _____

Social Security # _____ (optional)
Daytime Phone: _____

___ Request Health Information from ___ Send Health Information to ___ Discuss Health Information with:

The person named above authorizes information to be released from/to one of the representatives of:

Provider, OR Facility _____
Attn: _____
Address _____
Phone: _____ Fax: _____

Purpose of disclosure (check one)

- ___ Patient Request ___ Insurance
___ Review Patient Care ___ Continuing Care
___ Legal ___ Payment
___ Appeal Denial of Social Security Benefits
___ Other... Specify _____

THE PERSON NAMED ABOVE AUTHORIZES HEALTH INFORMATION BE SENT TO: (RELEASE RECORDS TO "NGPC")
ORGANIZATION(S) NAME: NORTH GEORGIA PAIN CLINIC (FACILITY) PHONE: 770-479-2322

___ All Health Information/Records ___ Specific Categories of your Health Information/Records
___ Specific Date(s)/Year(s) of Treatment _____

IF SPECIFIC CATEGORIES ARE SELECTED PLEASE INDICATE THE INFORMATION YOU AUTHORIZE TO BE RELEASED:

- ___ History/Physical ___ Diagnostic Studies
___ Progress Notes/Office Notes (Last 3 Visits) ___ Surgical Reports
___ Medication List ___ Laboratory Reports
___ Radiology Reports/Imaging ___ HIV Testing/Information
___ Emergency Room Reports ___ Drug/Alcohol Test Results
___ Discharged Letters ___ Other: _____

___ All information regarding care received between the dates of ___ (Start) and ___ (End Date)

Expiration: ___ When information is received ___ In six months ___ In one year ___ On Date _____

From Date: ___ To Date: ___ Date: ___ Initial: ___
Alcohol or Drug Abuse Treatment
Mental Health Treatment
HIV Status or Treatment

Signature of Patient or Authorized Representative
(if not patient, indicate relationship of authorizing person to patient)

Date

Signature of Witness

Date

Authorization for Release of Confidential Medical Information

Certain information is covered by additional protection and requires specific authorization. To authorize release or discussion of the following type of information, the person named above must initial and date each item. If an item is not initialed and dated the information, if such information exists, cannot be released or discussed.

The above-names person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this clinic or caretaker. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding the handling of your health information are outlined in our Privacy Practice document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient. Such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibly for benefits.

PLEASE NOTE: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from those other providers or facilities.

There may be a fee associated with the copying of your records. If for personal use, you are entitled to one copy of your personal health information record free of charge. Additional copies for you, future releases to you, or releases to other providers, persons or facilities may be subject to a reasonable charge Please contact a clinic office manager or site administrator for additional information about applicable copying fees.