NGPC

Return to:

770.479.2322 (phone)
770.720.7695 (fax)

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

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 _____ Social Security #_____(optional)

Date of Birth _____ 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 *Date*
(if not patient, indicate relationship of authorizing person to patient)

Signature of Witness *Date*

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 eligibility 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.